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# Family Planning and Social Work



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# Family Planning and Social Work

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## PREFACE

When the Family Planning Division of the Department of National Health and Welfare was formed in January 1972, it soon became apparent that one of the important needs in the family planning field was in the area of training for health and welfare professionals. At that time very few schools of social work, medicine or nursing offered courses on family planning or human sexuality. With a few notable exceptions persons already in practice had little in-depth knowledge or understanding of the subject. In some respects this is not surprising since prior to the 1969 Amendment to the Criminal Code the dissemination of information about birth control was illegal. Yet undoubtedly many of the clients or patients of health and welfare professionals needed this kind of help at some point in their lives.

Thus one of the objectives of the federal family planning program has been to encourage and assist the development of training and educational programs for professionals whose work encompasses some aspect of family planning or human sexuality. This assistance has taken a variety of forms. The services of the Division's professional consultants were offered to professional schools to assist in curriculum development and to health and welfare agencies to conduct workshops or help plan staff development programs. Family planning grants have been provided to support seminars, workshops and courses. A limited number of fellowships were made available to Canadian university faculties

to enable them to employ qualified persons to work full time teaching family planning or conduct operational, demographic or behavioural research.

The development of educational materials has also been an important component of the federal family planning program. The Division has already produced a resource manual for nurses and several pamphlets on various aspects of birth control. In 1976 work was under way on teaching materials for school sex education program.

Since there are now numerous sources of information on methods of contraception, it was thought that most useful publication for social workers -- students and practitioners -- would be a collection of papers written by social workers, published in both official languages, that would deal with the role of social workers in family planning and human sexuality and with some of the related issues and concerns. Although many aspects of the subject have been covered, some have been omitted; for example, it was not possible to locate a social worker who would agree to write on genetic or infertility counseling. For the same reason there is not a chapter on the use of indigenous family planning counsellors. It had been hoped that this book would include an article on a family life education program in a Roman Catholic agency. However, those persons who were approached declined on the grounds that their programs had only recently been introduced and, therefore, would not lend

themselves to be written up at this time.

It should be pointed out that opinions expressed in this volume are those of the individual authors and should not be regarded as representing the policy or philosophy of the federal government. Indeed, as might be expected, the reader will find that there is not complete agreement among all of the authors on all questions related to this field.

Cenovia Addy  
Social Services Consultant,  
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January, 1976



## INTRODUCTION

Cenovia Addy, B.A., M.A., A.C.S.W.

After generations of taboo family planning has gained a measure of respectability. Although in 1975 Canadian television still did not accept advertisements for contraceptives, many newspapers did so. They also carried numerous articles on various aspects of the subject. In Ottawa Mayor Lorry Greenberg proclaimed a family planning week for the city and participated in the opening ceremonies. By 1975 it was no longer uncommon to find family planning information booths in shopping centres in many communities or at local fairs and exhibitions.

While family planning services were once regarded as being mainly medical services, it is now recognized that they are not the exclusive domain of any one discipline. Family planning cuts across the fields of health, welfare and education. In fact, one can argue that most Canadians who use family planning measures probably do so for social or economic considerations rather than for reasons to maternal and child health. It was an awareness of the social and economic consequences of unplanned pregnancies that convinced many social workers that their profession had a role in family planning.

In attempting to identify their role in this field social workers have experienced many of the same problems and frustrations encountered by other individuals and groups with respect to

definitions and terminology. Whether a group is drafting government policy, organizing a conference or developing a program of services it finds itself grappling not only with the question of what they mean by "family planning" but also whether this is the best term to convey it. For this reason various groups prefer the following terms: planned parenthood, birth planning, birth control, fertility control, fertility regulation, conception control, conception prevention, birth prevention, family limitation and contraception. Although these terms are sometimes used interchangeably not all are synonymous; birth control might encompass abortion whereas conception control would not. To some people a term using the word "control" has a negative connotation. Others object to the word "family" because they feel that it excludes single persons. However, any group searching for a term acceptable to it ought to take into consideration the effect on the general public. Will people tend to understand the services of an agency that is known as a birth control centre more easily than if it were called birth planning clinic? How will a "fertility service" be perceived?

The Canadian government, like the governments of many other countries, uses "family planning" and the French equivalent, "planification familiale." On the other hand, for example, the largest national voluntary agency in the family planning field changed its name in 1975 from the Family Planning Federation of Canada to the Planned Parenthood Federation of Canada, not only

to bring its name in line with that of the International Planned Parenthood Federation, but also to convey a slightly different meaning. Many of the Canadian federation's provincial affiliates have also similarly changed their names.

A definition of terms is also important. Actually the process of defining terms usually operates simultaneously with the search for acceptable terms. Often while a group is deciding what it means by a particular term it concludes that another term may be more appropriate. Sometimes different groups define the same terms differently.

The Family Planning Division of the Department of National Health and Welfare has the following definition of family planning:

For the purpose of this federal program, family planning is defined as the knowledge and practices that enable couples to attain the following objectives:

- to avoid unwanted pregnancies;
- to bring about wanted births;
- to regulate the interval between pregnancies;
- to control the time at which births occur in relation to the ages of the parents;
- to decide the number of children they wish to have.<sup>1</sup>

The federal definition excludes abortion since the government does not regard this measure as an acceptable method of family planning. On the other hand, the Family Planning Division promotes the development of family life and sex education programs because such programs provide the knowledge base on which persons can make responsible decisions related to family planning.

In Saskatchewan the Family Planning Advisory Committee to the Committee of Ministers defines family planning as follows:

Family planning is defined as the process of the personal management of reproduction in all its aspects. Central to this definition are the issues of conception and contraception, birth, and care of a child or children. Thus, the decisions of whether or not one wishes to have children, when to have them, how many to have, under what circumstances to have them, how to care for and support them are basic to family planning.

Essential to family planning is the responsible expression of sexuality. The development of responsible sexuality is a life process resulting from experience and learning throughout life.<sup>2</sup>

Delegates to the First National Conference on Family Planning convened by the Department of National Health and Welfare in Ottawa, February 28 to March 2, 1972, recommended that:

Family planning policy, program and services should encompass the full range of birth control methods, sterilization (vasectomy and tubal ligation), abortion, fertility and genetics, as well as marriage and family (including adoption) counselling and assessment, diagnostic, referral and follow-up function.<sup>3</sup>

The readers of this book will find that terms and definitions vary according to the orientation of the particular author using them. It is also obvious that the range of topics covered goes beyond "family planning" as defined by the federal government. The treatment of sexual dysfunction, sexuality in the aging and population issues are examples. The rationale for their inclusion is that they are related to the broader topics of human sexuality and human reproduction and, furthermore, these are questions of increasing interest to social workers whether they are direct service practitioners, administrators or teachers.

# FOOTNOTES

<sup>1</sup>Canada, Department of National Health and Welfare, Family Planning Division, Family Planning (Ottawa: Department of National Health and Welfare, 1972), p. 1. . (Phamphlet)

<sup>2</sup>Saskatchnewan, Department of Health, Family Planning Advisory Committee, Report of Family Planning Advisory Committee to the Committee of Ministers on Family Planning (Regina: Department of Health, 1975), p. 1.

<sup>3</sup>Canada, Department of National Health and Welfare, Family Planning Division, Recommendations of the First National Conference on Family Planning (Ottawa: Department of National Health and Welfare, 1972), p. 4.



A HISTORY OF THE FAMILY PLANNING MOVEMENT IN CANADA  
(PLANNED PARENTHOOD FEDERATION OF CANADA AND  
LE CENTRE DE PLANNING FAMILIAL DU QUEBEC)

Raymond Boutin, M.S.W., P.S.W.

Man has sought to control his reproductive activity at all times throughout the ages. Historians do not agree, however, on the origins of contraception.

The first contraceptive instructions probably were written on papyrus scrolls in Ancient Egypt, 1,850 years before Christ. About the 2nd century AD. a Greek gynecologist, Soramus of Ephesus, described various contraceptive methods; these writings were used until the seventeenth century. Charles Knowlton probably contributed the next such reference with his book The Fruits of Philosophy or The Private Companion of Young Married People, which appeared in the United States in 1832. About this time Thomas R. Malthus expressed concern that overpopulation -- unless checked by birth control, disease, war etc. -- would lead to widespread poverty.

In Holland, a medical service was opened in 1882 by Aletta Jacobs. In 1912, Margaret Sanger visited this service and other clinics and despite the law in the United States, she, her sister Ethel Byrne and Tania Mindell, a social worker, opened the First American clinic in Brooklyn, New York in 1916. All

three were arrested under the 1873 Act prohibiting contraception and convicted on charges of "maintaining a public nuisance."

In England Marie Stopes, who had written Married Love and Wise Parenthood, opened her first family planning clinic for poor women in 1921.<sup>1</sup>

#### Canadian Beginnings

The first Canadian efforts took place in the early thirties in three different locations -- Kitchener, Hamilton and Winnipeg -- and were to have an impact on changing attitudes and the development of widespread acceptance of contraception by Canadians. These initial moves were made illegally, since legislation under the Criminal Code had been passed in 1892 forbidding the sale or advertising of contraceptive devices or methods and the dissemination of information about birth control.

In Kitchener, A.R. Kaufman, owner of the Kaufman Rubber Company, became involved in family planning as a result of the economic difficulties many of his employees faced at the beginning of the Depression in December 1929. He founded the Parents' Information Bureau, which is still active. The peak of its career was before the Second World War; at one point 75 people across Canada were paid to make home visits and take information and services wherever they were desired. In 1964, 200,000 women were registered with this bureau.<sup>2</sup>

This activity, was not to pass unnoticed. In September 1936 Dorothea Palmer, a visiting social worker, was arrested and

accused under a Criminal Code provision forbidding family planning activity unless it was "for the public good." Several women who had received the services of Miss Palmer (who was backed by Mr. Kaufman) testified at the 23-day trial, stating that they had received a needed service. The Crown was therefore unable to prove that this service was not for the public good and Miss Palmer was acquitted on March 17, 1937.<sup>3</sup> This decision gave a boost to family planning activities in Canada, although they remained illegal under the 1892 legislation. In addition to home visits and correspondence work, Kaufman also financed a clinic at Toronto from 1933 to 1938. It was closed because of its cost; home visits were found to be more effective.

Kaufman's initiative was an inspiration to Mary Elizabeth Chambers Kawkins, an American who had come to Canada in 1900 with her husband and children. In 1930 she thought of opening a clinic in Hamilton. She tried to convert her friends to the idea, influence the people around her, increase their awareness of the problem and even send doctors to New York for training. The clinic opened in March 1932 and remains open to this day, despite the difficulties and resistance it encountered (financial, legal and religious problems, public rejection and so on). A social worker, Gertrude Burgar, soon became an associate of Mary Hawkins. Dr. Elizabeth Bagshaw became the clinic doctor and continued, almost on a voluntary basis, until 1966. The Planned Parenthood Society of Hamilton was finally awarded its charter by the Ontario

government in 1966, three years before the sale and advertising of contraceptive products as well as the provision of services<sup>4</sup> became legal.

On January 28, 1934, the Winnipeg Birth Control Society was founded by Mrs. H.M. Speechly. This was a home-visit service and not a clinic. A small number of physicians and nurses provided the medical backing. In 1967 the Social Planning Council of Winnipeg, as a result of its study of that community's health and social needs, decided to support this association, which is now known as the Family Planning Association of Manitoba.<sup>5</sup>

#### The Formation of the Planned Parenthood Federation of Canada

By around 1960 there has been such progress with the concept of family planning that the majority of Canadians no longer felt that the size and spacing of one's family had to be left to nature. However, even though attitudes had changed, changes were needed in laws, services and financing. Only one strong national volunteer organization could channel all the energies necessary to re-establish a balance between services demanded and services offered.

At this point George and Barbara Cadbury appeared on the Canadian family planning scene. This was not their first battle for social change. In fact when Barbara Cadbury, the daughter of a British feminist, had been elected town counsellor in 1934 for the district of Stoke-Newington in England. One of her first acts had been to request that the city health services supply family planning services. When her husband was working

in New York for the United Nations, Mrs. Cadbury was in charge of a journal called "Round the World News of Population and Birth Control." She was associated with Margaret Sanger in founding and editing it. In this capacity she was in contact with a large number of Canadians who asked to be added to the mailing list. In 1960 Mr. George Cadbury resigned from the United Nations to become an almost full time officer of the I.P.P.F. After travelling for the I.P.P.F. more than six months in 11 Asian countries, he and Mrs. Cadbury settled in Canada in 1961. Using the mailing list then, they got in touch with Canadians interested in family planning and played a catalyst role.

In Toronto in the fall of 1961 the Cadburys called a public meeting for all those interested or likely to be interested in the cause of family planning in Canada. This meeting led to the beginning of Planned Parenthood of Toronto, founded officially in the spring of 1962. From the beginning the organization was on the offensive to get the law changed and soon presented a brief to the federal Royal Commission on Health Services. Such action provided the organization with an ideal public platform on which to battle public misunderstandings about family planning.

Soon people began to contact the Toronto association for information about contraceptive methods and for help with problems of infertility. The association also quickly initiated a quarterly news bulletin sent to more than 800 people.

In Vancouver, the Society for Population Planning was



founded in 1961, and its constitution and regulations were adopted in December 1962. Its provincial charter was granted in 1963 and it changed its name to the Family Planning Association of British Columbia in 1964. The first clinic was opened the following year.

In Ottawa, Rev. David Pohl succeeded in forming an association in 1963 under the name of Ottawa Society for Population Plannings.

The increasing interest in family planning in Canada led to the formation in 1963 of the Canadian Federation of Societies for Population Planning. The federation's objectives were as follows:

- (a) to provide a national organization for societies and associations with similar objects and to represent such societies and associations before any international planned parenthood association;
- (b) to promote research and education on population problems, both domestic and international;
- (c) to inform the public on the problems arising from uncontrolled population growth;
- (d) to promote the understanding and adoption of family planning and to encourage good citizenship through responsible family life.

The federation's first general assembly was held in 1964; the second took place in 1966 in Ottawa, when the federation's name was changed to the Family Planning Federation of Canada (Fédération pour la planification familiale du Canada). Starting in 1967, the general assemblies became an annual event held in various Canadian centres. In 1975 the federation's name was again

changed to Planned Parenthood Federation of Canada/La Fédération pour le planning des naissances to conform with popular usage.

At its formation in 1963, one of the new federation's first tasks was to join together all the organizations already involved in family planning. Initially those in Toronto, Vancouver, Hamilton, Winnipeg and Ottawa were integrated. To gain more support and thus more credibility, they sought the support of various Canadian churches. In 1966 when Montreal and Edmonton joined the federation, the United, Presbyterian and Anglican Churches while already involved in the activities of the Federation, became members along with the Canadian Unitarian Council. The federation became a member of the IPPF in 1963.

The federation's main target was the 1892 legislation forbidding the sale or advertising of birth-control devices or methods or the provision of related services. Robert Prittie, a member of Parliament from 1962 to 1968 and a charter member and vice-president of the federation, provided one means of attack by presenting almost annually a private member's bill in the House of Commons calling for removal of all mention of contraception from the Criminal Code.

In addition to working to have the law changed, the federation also presented briefs to such bodies as the Parliamentary Committee on Health and Welfare and the Royal Commission on the Status of Women and the Senate Committee on Poverty as well as making representations to the Vanier Institute of the Family, the

National Film Board, members of Parliament and professional associations for physicians, nurses, social workers and so on.

The 1892 legislation was finally changed in August 1969 and from that point on governments could officially establish policies concerning family planning. The battle was far from won, however, since services had to be organized and staff trained. Volunteer organizations would again be called upon to play an important role.

#### Development of the Federation

In a speech to the federation's 1969 general assembly John Munro, then Minister of National Health and Welfare, indicated a coming change both in the law and in federal support of volunteer organizations providing family planning information to all.

Federation members set to work: they prepared information, and pressed the provinces to provide family planning services. As soon as the legislation was changed in August 1969, efforts were made to incorporate the federation and have it recognized as a charitable organization; this was accomplished by December 1969.

A loan from the IPPF made it possible to hire a fund-raiser in January 1970. An office in Toronto replaced the small one that had been in Montreal since 1968. Funds were obtained from various private organizations, Miles for Millions in particular. The federal government promised support in 1971 and Brian Strehler, who had been the fund-raiser, became the

federation's executive director. The federation received its first \$100,000 from the Department of National Health and Welfare in 1971 and lost no time in offering assistance -- financial and otherwise -- to the increasing number of member associations that were springing up. From only a handful of such associations in 1969, the federation grew to 77 associations and affiliates by June 1975; each province and territory now has its own association. With representation across Canada, the federation kept in touch with federal and provincial government authorities in both health and social services and in education in order to express family planning needs and help set up a program.

One of the most imperative needs was for information. With federal aid an information campaign was launched in 1973, using newspapers, the radio, and public transit advertising. (One poster message drew particular attention: "If you're old enough to get pregnant, you're old enough to know how not to.") A catalogue of family planning resources was prepared, along with a leaflet on contraceptive methods and teaching material in five languages. A quarterly bulletin was sent to 80,000 individuals (mainly professionals) and organizations.

On the national level the federation was in contact with a number of intermediary bodies and professional associations in order to make them more aware of their role in family planning education.

Internationally the federation played an important role

despite its youth. It maintained regular contact with international organizations such as the IPPF and with no less than 87 countries. Over a period of five years it was able to raise mainly through Miles for Millions and matching grants from the Canadian International Development Agency some \$300,000 for family planning projects in other countries.

In 1973 the federation formed a population division to inform the public of population problems. The publicity arising from World Population Year in 1974 helped. Through its part in holding regional and national conferences in Canada in 1974, the federation contributed to the government's representation at the World Population Conference in Bucharest that year. The federation continues to educate the public on population problems and to press for an official Canadian policy on population.

#### Le Centre de Planning Familial du Quebec

In the meantime there were great accomplishments in Quebec under the impetus of Serge Mongeau, physician and social worker, who founded the centre de Planning Familial du Quebec in Montreal. When Dr. Mongeau was a medical student he lived and worked in a disadvantaged area of Montreal and quickly became aware of the family planning problem. He soon became involved in the activities of the Family Planning Association of Montreal and at one point was its president.

In September 1965 the Montreal Community Council organized a preliminary meeting with representatives of social agencies. The



accent was on the social aspects of family planning rather than the medical ones. As Dr. Mongeau put it: "It is appropriate that work in this field be removed from the medical field and put in the area of social services and related disciplines, such as psychology..."<sup>6</sup> On April 28, 1967 Dr. Mongeau became director of the centre de Planning Familial du Québec once the project was given approval and financing by the provincial government. The provincial support was particularly significant in that it preceded the changes in the Criminal Code provision relating to contraception. The centre soon became a member of the Planned Parenthood Federation of Canada. Its objectives were to assist social agencies, do research, integrate the medical and social aspects of family planning and find resources. In addition to courses for social workers, nurses and teachers given throughout the province, the centre developed a research component in 1968 and in 1969 opened a clinic in Montreal, one of the objectives of which was to test the "psychosocial concept followed by the centre de Planning Familial du Quebec."<sup>7</sup> In 1969 a division for sex counselling was opened, as well as an international division. The centre was incorporated in 1970; its application had been signed by three eminent Quebec social workers, all of whom directed social agencies: Gérard Sylvestre, Roger Prud'homme and Yvon Belley. However, for a number of reasons including internal problems and the restructuring of Quebec's health and social services the centre was closed on July 1, 1972. Its services

were absorbed by various other agencies.

In closing, two points bear emphasis: the role of social workers in the Canadian family planning movement and a review of its future tasks.

It is often said in family planning circles that social workers are, or were, absent from the scene. In fact, however, they were active in almost all stages of the movement. Many of our associations have been established or directed by social planning councils. The Quebec movement in particular has emphasized the psychosocial aspects of family planning. The desire was to study family planning in all its aspects, not only from the medical point of view.

The Planned Parenthood Federation of Canada is continuing the fight to lower the age of majority in order to give sexually active teen-agers access to family planning services. It also works to promote proper sex education, presses provincial governments for adequate family planning services, and fights ignorance and taboos. The objective? That each conception be a planned one.

<sup>1</sup>Encyclopaedia Britannica, 1974 ed., s.v. "Birth Control," by E.E.N. Draper, pp. 1-2.

<sup>2</sup>Ian Bain, "The Development of Family Planning in Canada," (unpublished text of a course given at the School of Hygiene, University of Toronto, 1964), pp. 3-5.

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<sup>4</sup>Thomas Melville Bailey, For the Public Good. A History of the Birth Control Clinic and the Planned Parenthood Society of Hamilton, Ontario, Canada (The Planned Parenthood Society of Hamilton, 1974).

<sup>5</sup>Bain, "A First for Family Planning," The Globe and Mail, 13 November 1965, p. 6.

<sup>6</sup>Serge Mongeau, "Historique du Centre du Planning Familial du Québec." p. 3, translation of excerpt.

<sup>7</sup>Mongeau, p. 8, translation of excerpt.

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## SERENA CANADA: TWENTY YEARS OF FAMILY PLANNING ACTION

Marie-Paule Doyle, M.S.S.

Volunteer action in the area of family planning in Canada is a mosaic of experiences reflecting the culture, values and models of services adopted by the groups and sub-groups that make up the country. Service de Régulation des Naissances represents one of the major facets of this mosaic.

### Twenty Years of History

Serena's work began in 1955 at Lachine, Quebec near Montreal.<sup>1</sup> It was the idea of a young working-class couple, Gilles and Rita Breault, who were faced with an important family planning problem after having three children in quick succession. They felt they owed it to themselves and to their stability as a family to find a way in which to control their fertility both effectively and in keeping with their values. The Breaults must have had a rare curiosity and spirit of inventiveness because, by reading about ovulation in several medical texts, they reached a hypothesis for practical observation of the progress of the menstrual cycle.

The Breaults accumulated personal observations, made themselves familiar with all available works on the subject and made a synthesis of all this data. They patiently gathered evidence for their theory that, by observing both certain signs prior to a woman's ovulation and recording her basal temperature



afterward, it was possible to pinpoint her ovulation time and easily and accurately find the infertile phase of 12-to-16 days between ovulation and the following menstrual period.

Gilles and Rita Breault shared their discoveries with friends and neighbours. Gradually symptothermic graphs were accumulated and rules for their interpretation developed. The word spread; more and more couples asked for appointments to see them. The demand became so great that the Breaults trained helpers and began work as a team. The circumstances of the first applicants for their help were varied: couples in which the wife suffered from a heart condition or cancer, couples who had already transmitted hereditary diseases to their children, couples who had slept in separate bedrooms for years.

From 1955 to 1962, there was little publicity for the work of the "Breault team." However, following an article in 1962 in "La Revue Populaire" and a television program, they received 2,000 letters, each one more pathetic than the last. The Serena couples began to write answers at their kitchen tables to all these requests from French-Canadians; all were answered within a couple of months. Fortunately, along with all the couples requesting services, other couples were offering to provide them. The new problem was to train these people and check their competency. A training program was set up and an admission examination prepared. From 1963 to 1965 about 20 teams sprung up in the province of Quebec, along with a few in

Ontario and New Brunswick.

A great need was soon felt for structuring and coordinating all these good intentions. This began in 1965 with the election of the first couple as presidents of the movement, and the development of a board formed of representatives of regions in which the teams were located. The body had no secretariat, and so jobs such as work on training programs, developing examinations, liaison and annual training activities had to be shared. In 1968 Serena received its first government grant from the Quebec Department of the Family in recognition of the value of its service. This grant has been renewed every year since then. In 1969 Serena Inc. received its letters patent and was recognized as a charitable institution. Two years later, in 1971, it received its first federal grant, enabling it to start offering services to English-speaking clients. One by one the provincial groups became provincial corporations and in 1974 a more complete national structure was created under the name Serena Canada. As well as its Quebec government grant the organization receives a support grant from the Family Planning Division of the Department of National Health and Welfare and is also developing its own independent financing.

Early in its history Serena took its place on the international scene. Before it was even completely organized in Canada, for example, a South American group asked it to sponsor an information program at Cali, Columbia, on family planning

through natural approaches. (Since 1972 the Canadian International Development Agency has provided Serena with considerable support in this project.) Out of Serena's international work grew a fervent wish on the part of numerous groups that had been in close contact with it for some years for an international federation. The founding meeting of the International Federation for Family Life Promotion/Fédération Internationale d'Action Familiale (FIDAF)<sup>2</sup> was held in Washington, D.C., in August 1974, a few weeks before the Bucharest Conference on Population.

### Serena's Philosophy

Serena's involvement in family planning is within an overall context of a loving relationship and family dynamics. Control of fertility is not assured simply by distributing effective contraceptives, as experience has now proven.<sup>3</sup> All human acts or failures to act are influenced in a complex way by the person's aspirations and fears, drives and needs; and the dynamics of human reproduction are all the more complex because two people are directly involved.

Serena tries to involve the man and woman equally in seeking information on fertility, choosing a method for family planning and sustaining the application of that method. This is not always possible, but experience has proven that it is more profitable for the couple's interpersonal relationship and their success in family planning to motivate the two partners in the initial stage rather than after a failure or abandonment of contraception.

In an attempt to involve both partners in decisions about family planning and to give them a model to identify with (thus strengthening their motivation), Serena offers the services of a trained couple to help educate and assist them. The couple-to-couple situation often enables a new kind of dialogue to develop between the man and woman seeking assistance.

#### Peer Teaching

The peer-teaching practice is not unique to Serena. This approach meets with the approval of those who are against a society that is so specialized that individuals feel inadequate to deal with even the slightest challenges in their every-day life. The Serena monitors know that it is possible in most cases to become aware of oneself as a fertile being and to be in control of this potential without recourse to "specialists." They offer to share their knowledge and experience with others. Thus they reinforce or develop the potentials of people who consult them.

Meetings with Serena couples are often held at home. The atmosphere is relaxed and friendly. The consulting couple then uses the telephone to get the necessary help to interpret their first temperature graphs. The monitor couple is available for consultation 24 hours a day, holidays included, but consulting couples never abuse this privilege. Such a service is inexpensive to operate. Rural areas and small villages can also be served by means of such a flexible and inexpensive method.

### Accent on Knowledge and Independence

Serena stresses the transmission of the most complete information possible concerning the mechanisms of human reproduction and the means of predicting conception. Knowledge about fertility does not remain at the theoretical level; it is applied so as to allow any interested couple to become familiar with their own fertility cycle and to know every day and any day the likelihood of conception. Thus the couple has complete freedom to use this knowledge either to conceive a child or to prevent conception.

While Serena specializes in teaching natural methods of family planning, it discusses with couples who wish it the mechanisms, advantages and disadvantages of all contraceptive methods. The couple chooses the method that seems most suitable and of course may change methods if they wish.

### Natural Methods

Serena has 20 years of experience in teaching natural family planning methods, particularly the symptothermal method. Serena has chosen this option for several reasons. Observation of the signs of ovulation and the basal temperature provides a woman with a great deal of information on the mechanism of her menstrual cycle and allows her to understand herself as a woman more fully and to control her own destiny. The symptothermal method supplies information on ovulation, the pre-menopause, the post-partum period, fertility while breast-feeding, etc. Observation of the signs

of ovulation and the basal temperature also allows the fertile and infertile periods of the menstrual cycle to be determined precisely so that a couple can choose when to have sexual relation depending on whether they wish to conceive a child or avoid conception.

Periodic abstinence guided by the basal temperature and the signs of ovulation is a very effective method of family planning. A recent survey<sup>4</sup> that gave an overview of 1,000 couples in five countries two of them emerging nations showed that in the Canadian sample of 168 couples (3,822 exposure cycles) the overall practical failure rate according to the Pearl formula was six pregnancies per 100 women years, while for couples desiring not to space but to limit their family the failure rate dropped to 1.1 pregnancies per 100 woman years. Teaching natural methods suits couples wishing to provide a direct service in family planning. They do not have to have a great deal of medical knowledge in order to teach but the knowledge required to apply the symptothermal methods is complex enough to require couples seeking help to consult the monitors.

#### Serena Canada's Structures and Activities

The structure of Serena is centred on local need. The local team is the basic unit of the services. It must consist of at least two accredited couples and usually has the assistance of both a moral adviser and a medical advisor. The local team is responsible for co-ordination of activities in its area, and

trains new monitor couples.

All the local teams in the same district are grouped together. Each local team is represented by one couple. The region's role varies in importance according to the team's wishes, its geography and the traditions of co-operation between the various cities. Each regional team delegates a couple to the provincial board. In turn, each provincial group that is incorporated delegates a couple to the national board. This method of delegation keeps the national board in direct contact with the grass roots. Serena has some 40 teams spread over eight provinces. The majority are in Quebec because Serena has not been active long in English-speaking areas outside that province. By 1975 more than 200 monitor-couples living in more than 100 different cities were accredited to offer services. Quebec and Ontario have provincial secretariats that share the task of training and organizing teams with the national secretariat.

Serena's activities are many and diverse, but two major ones are its assistance to couples and its publications. In 1974 a total of 4,444 couples received training in the sympto-terminal method and 2,131 of these were sufficiently informed that they could use the method if they desired. The Serena couples also met 13,022 people to discuss fertility, family planning, sexuality and the expression of love. More than 13,500 persons have also had the opportunity to find out about Serena's services and to familiarize themselves with the organization's views on



subjects related to family planning. In 20 years Serena has provided teaching in family planning to more than 50,000 couples and directly reached close to 200,000 persons.

Serena has published "Love and Life," a brochure on fertility and all methods of family planning. The 350,000 copies of the first printing of the French version of the brochure, "Faire L'amour, faire un enfant?" was rapidly distributed, as was the revised version, "Fécondité et régulation des naissances." The 550,000 copies of the English version received an equally favorable response.

Serena Canada is a dynamic organization that was begun as the result of a need and which continues to exist because it fills a need. Its educative approach contrasts with the current technological approach and opens new horizons in the development of models for service.

## FOOTNOTES

<sup>1</sup>Rita and Henry Breault, Les idées nouvelles viennent de la base, [New Ideas from the Grass Roots] (Ottawa: Serena Canada, 1976).

<sup>2</sup>Rédération Internationale d'Action Familiale - International Federation for Family Life Promotion, 1776 K Street NW, Suite 701, Washington, D.C., 20006, U.S.A.

<sup>3</sup>René Cloutier-Cournoyer, Planification des naissances en milieu défavorisé urbain québécois, [Family Planning in Disadvantaged Urban Areas of Quebec] (Québec: Laval University) 1975.

<sup>4</sup>Suzanne Parenteau-Carreau, "Etude internationale Fairfield sur l'efficacité de la méthode sympto-thermique de régulation des naissances" Fairfield Internatinnal Study on the Effectiveness of the Symptothermal Method of Family Planning, Canadian results compared to overall results. La Vie Médicale au Canada Français, 1975.

## PHILOSOPHY OF FAMILY PLANNING: VALUES AND ISSUES

Cenovia Addy, B.A., M.A., A.C.S.W.

Canadian family planning programs are based on the philosophy of the individual's right to control his or her own fertility--a concept social workers can accept because it is compatible with the right to self-determination and with most people's perception of a democratic society.

Most social workers recognize that family planning is not a panacea for poverty, child neglect or abuse, illegitimacy or abortion. Nor is it a substitute for adequate social assistance, decent housing at reasonable cost, day care programs, a realistic minimum wage, good medical care or a host of other social and health measures. But social workers are familiar with the misery that can result from unwanted pregnancies: too many children too closely spaced can endanger the mother's physical or emotional health, can deplete her energies, can increase the risk of infant mortality and prematurity, can lead to severe strains on the marital relationship and can be an economic disaster for some families. The problems associated with illegitimacy--for the child as well as for the unmarried mother--are also well known to social workers.

While social workers generally accept the individual's right to control his or her own fertility, conflicting values become apparent in the interpretation or application of this

principle. In this respect social workers are no different from the general public. There is broad acceptance of family planning for married couples. Every major church group agrees that couples should responsibly plan the number and spacing of their children, according to their own wishes, although differences exist regarding the acceptability of specific methods. But there is less acceptance of contraception for unmarried persons, no doubt a reflection of disapproval of sexual activity outside marriage. Divorced, widowed and separated women, particularly if they have children, experience varying degrees of difficulty in finding a physician who will prescribe contraceptives. In the same way, some social workers guard against imposing their own values on their clients in most spheres, but while these social workers are comfortable discussing contraception with a married client they find it difficult to refer a female head of a one-parent family to a birth control clinic.

One of the most controversial issues--one that most certainly has implications for social workers--centres on whether contraceptives should be available to sexually active minors without parental consent. The legal age of consent for medical care is governed by provincial statutes and varies from province to province. Some people argue that allowing adolescents access to contraceptives is tantamount to condoning, if not encouraging, sexual activity among them. Such persons feel that doctors who provide such service to minors without parental consent ought to

be liable to charges of contributing to juvenile delinquency. Some suggest that social workers, teachers and nurses who give information regarding birth control should be equally liable. Those on the other side of the issue argue that most minors who seek birth control are already sexually active and that withholding access to contraceptives will not ensure abstinence; instead it may result in an unwanted illegitimate pregnancy, which they regard as more problematical than sexual activity. Child welfare agencies are increasingly grappling with this issue; several have developed policies which permit the referral of an agency ward to a birth control clinic or a private physician.

Meanwhile family planning groups and others have pressed provincial governments to lower the age of consent. However, differences of opinion exist regarding an appropriate age. Some people advocate age 16; others suggest age 14. The membership of the Canadian Council on Social Development passed the following recommendation at its 1975 annual meeting:

Conception control measures should be available to every individual of childbearing age after proper counselling is received. This recommendation is addressed in particular to the provinces, who are urged to examine their legislation relating to age of consent.\*

An even more contentious issue is that of abortion. Like the general public, social workers have strong opinions about it.

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\*See appendix for a complete list of recommendations on family planning adopted at the council's annual meeting.

However, they are confronted with the problem of how to proceed when an agency client seeks help in securing a therapeutic abortion as a solution to an unwanted pregnancy, or wants to discuss several options, of which abortion is one. Family service and child welfare agencies in particular tend to differ from agency to agency in their philosophy toward abortion--child welfare agencies because of their responsibility, in loco parentis, for the medical care of their wards and their service to unmarried mothers. Some agencies have spelled out the circumstances in which an abortion may be considered for a foster child, and have set up specific procedures for making decisions on individual cases; others prohibit giving any consideration to abortion.

In some agencies abortion is regarded as one of the options which may be available to unmarried mothers. Social workers are given the authority to offer counselling to any client who wishes to discuss abortion and, if appropriate, to actively support referral to a doctor. Agency social workers whose moral or religious beliefs conflict with such policies are expected to withdraw from a case involving a request for abortion counselling so that the case can be reassigned to another worker.

On the other hand some child welfare agencies consider their primary function to be the protection of children, including the unborn. Social workers are expected not to discuss abortion with clients. In other agencies where abortion is officially opposed, discussion with adult clients is permitted in instances

when abortion has been adjudged by the woman's physician to be medically necessary to save her life.

The situation with respect to abortion counselling is similar in some respects to that of divorce counselling 25 years ago. Some agencies regarded divorce as a realistic option in a hopeless marriage and permitted their staff to discuss it with clients. Social workers who opposed divorce on moral grounds were expected to transfer potential divorce cases to other workers who were not. In other agencies no discussion of divorce was permitted. In comparing the two situations it is not suggested that in another 25 years abortion will be as acceptable to social workers as divorce is now. It is impossible to predict to what extent, or in what direction, society's values with respect to abortion will have shifted by that time.

Voluntary sterilization as a method of birth control is also opposed on religious grounds by some social workers. Others see it as a practical measure for couples who have completed their families and who can accept the finality of such a decision. Some physicians and hospitals require the husband's consent for tubal ligations but do not require the wife's consent for a vasectomy; some women's groups, particularly, take issue with this. In some communities it is difficult to obtain a voluntary sterilization because of the religious beliefs of the physicians or the philosophy of the hospitals.

The resolution of all these issues by individual social



workers and by society as a whole involves value judgments. In my opinion there is a key question that social workers, and others for that matter, should attempt to answer for themselves, because its resolution is basic to that of many current family planning issues. The question is: What constitutes responsible sexual behaviour? If asked, most Canadians would say that they are in favour of it; and it is not uncommon to see the acquisition of this attribute listed as one of the objectives of sex education. Yet an individual's definition of responsible sexual behaviour, for himself or for others, will depend to a large extent on his own value system.

During discussions with social work students, practising social workers, agency administrators, board members and social work educators in many parts of the country, I have found that sooner or later the importance of responsible sexual behaviour is mentioned. However, there are wide variations in the definition of this term. For some it means that sexual intercourse should occur only between two people who are married to each other. Others are less concerned about the marital status of the persons involved but believe that the quality of the relationship is important. Some will say that it simply means not exploiting a sexual partner. Some people regard fertility control as a responsibility as well as a right. For them, responsible sexual behaviour means preventing conception unless both partners, married or unmarried, actually want a child at that particular time and are

willing and able to care for it. For others, responsible sexual behaviour may mean not contributing to what they believe is already a world-wide problem of overpopulation. The significance of the meaning of this term for individual social workers lies in the influence their values exert on their relationships with clients, and also in the influence which these values may exert in forming agency policy or planning agency programs.

One cannot expect complete agreement among social workers, but each of us needs to be aware of what expectations we set for ourselves and others when we speak of responsible sexual behaviour. We also need to accept the existence of a broad range of sexual values, not only among our clients but also among our colleagues and in the larger community.

PUBLIC FAMILY PLANNING POLICY: FORMULATION AND IMPLEMENTATION

C. Norman Knight, B.A., Dip. S.S., M.A.

Social workers will presumably be interested in this sketch of family planning policy development in Canada for at least two reasons. They are professionally concerned with the processes by which governments become increasingly involved in meeting human needs and the complex of forces which influence the timing and nature of that involvement. In addition, a number of social workers played significant roles, as staff members of the Department of National Health and Welfare, in the evolution of the present federal program.

In retrospect, a report delivered to the House of Commons on December 5, 1966, by its Standing Committee on Health and Welfare,<sup>1</sup> emerges as a landmark. That committee had, since February of the same year, been studying four proposals to amend Section 150 (2) (c) of the Criminal Code, which generally prohibited the advertisement or sale "of any means, instructions, medicine, drug or article intended or represented as a method of preventing conception or causing abortion or miscarriage."

In the course of 15 meetings the committee heard statements and received expert evidence from many interested organizations and individuals. Its report not only recommended the legislative path the government eventually followed, but also offered assurance that this path would be widely accepted and provided a principled

base for positive government action. It asserted that "the dissemination of family planning knowledge should be completely available and completely free from illegality, as a matter of personal choice"<sup>2</sup> and recommended the removal of the words "preventing conception or" from Section 150 (2) (c) of the Criminal Code. It also recommended that federal control of commercial advertising and distribution of contraceptives be retained through amendment of the Food and Drugs Act and Regulations. The committee was clearly satisfied that its findings would not provoke an adverse reaction from any major religious body, since the report "commends the Canadian Catholic Conference, as well as the other church groups which appeared before it, for their progressive views on the legislation respecting birth control. . . ."<sup>3</sup>

It was August 1969 before the necessary legislative changes were effected. Federal law now does not restrict non-profit agencies from disseminating information concerning contraception. The Food and Drug Regulations have been amended to authorize commercial advertisements of contraceptives in the mass media, except for "the pill" and intra-uterine devices. These methods, which require medical prescription, may be advertised only in professional journals.

Several briefs presented to the Commons committee during its study of the Criminal Code included evidence of the inadequacy and uneven distribution of existing family planning services and urged government action to remedy the situation. The committee's findings naturally intensified pressure on the government. In

addition, the work of two other federally appointed bodies -- the Royal Commission on the Status of Women in Canada and the Special Senate Committee on Poverty -- helped to maintain public interest.

In February 1969 the Honourable John Munro, then Minister of National Health and Welfare, met with representatives of the Family Planning Federation of Canada, at their request, for an informal exchange of views. The moving spirit of the group was George Cadbury of Toronto, but Hamilton, the minister's home base, was well represented. The Hamilton Family Planning Association, which organized the first voluntary family planning clinic in Canada, is one of the oldest and most respected organizations of its kind. In April Mr. Munro directed the formation of a joint working party, involving both the Health and Welfare sides of the Department, to develop a Cabinet memorandum on family planning. Dr. R.B. Splane, then Director General of Welfare Assistance and Services, was appointed to coordinate the work of the Welfare side on this project. Mr. E.I. Smit, then Branch Consultant on Family and Child Welfare, became chairman of the working party. Several other social workers, including the writer, then a policy consultant in the Canada Assistance Plan administration, represented the concerns of other departmental programs.

The Cabinet memorandum is a recognized method used by a minister to propose a new program or a major change in an existing program for consideration by his colleagues. The final document may be the product of weeks or even months of drafting and redrafting

and discussions with the various interests concerned, including the Privy Council Office and Treasury Board. Information is required about the organizational, financial, administrative and political implications of the proposal and its effect on related programs, outside as well as within the department primarily concerned. In this instance, a variety of interests within the Department were involved because they constituted resources actually or potentially available to support family planning activities. These included the Hospital and Diagnostic Services Act, the Medical Care Act and the Canada Assistance Plan as well as project grant programs on both the Health and Welfare sides of the Department. The Food and Drug Administration was also concerned because of its responsibility for the control of advertising. The international implications of an active family planning program in Canada required discussion with the Canadian International Development Agency and the International Development Research Centre.

A Cabinet decision made in July 1970 and announced by Mr. Munro in September<sup>4</sup> stated that the government recognized and supported the right of Canadians to exercise free individual choice in the practice of family planning and expressed the hope that, through the program, family planning information and services would become available to all who want them. Mr. Munro said his department would encourage research in family planning in collaboration with provincial governments, universities and private agencies and assist in relevant training activities. The statement emphasized

that the use of family planning is a decision to be taken by the individual citizen and that primary responsibility for the organization and administration of family planning programs rests with the provinces. While Cabinet at that time did not allocate any additional resources for family planning purposes it did authorize the use of federal grant and federal-provincial shared cost programs as potential sources of support for family planning activities. It also authorized the establishment, within the Department of National Health and Welfare, of a unit to initiate and advise on program development and to serve as a clearing house.

Over the next year or so the program evolved as a combined operation of the Health and Welfare sides of the Department under the joint direction of Dr. Splane and Dr. E.A. Watkinson, Assistant Deputy Minister for Health Services. Mr. Munro summarized developments during this period in a document tabled in the House of Commons on May 6, 1971.<sup>5</sup> He noted that amendments to the Criminal Code and the Food and Drugs Act had removed any barrier to the dissemination of information relating to the prevention of conception. Changes in the Food and Drug Regulations had made it clear that, with the exception of intra-uterine devices and drugs required to be sold only on prescription by a physician, contraceptives could be advertised to the general public in any way except by distributing samples through the mail or door-to-door. His department had supported the efforts of the Family Planning Federation of Canada to obtain charitable status under the Income Tax Act, and this had



been granted in 1970. To assist the government to determine Canada's needs and priorities in family planning, departmental officials had met with non-governmental specialists in Ottawa on February 8 and 9, 1971, and on March 22 and 23 with representatives of the provinces and territories. The Minister summarized the objectives of the program and outlined the resources available within the Department's grant and shared cost programs to achieve them. He also announced a direct grant of \$100,000 to help the Family Planning Federation of Canada extend its activities.

The response to the federal initiative by the general public, voluntary agencies, the professions and the provinces, together with several other developments, created pressures on the government to step up the program. Among these were the findings of the Royal Commission on the Status of Women, published in September 1970.<sup>6</sup> The commission recommended that birth control information be made available to everyone and that the Department of National Health and Welfare prepare and offer birth control information free of charge to provincial and territorial authorities, associations, organizations and individuals and provide financial assistance through its grants programs to train health and welfare workers in family planning techniques. It further recommended that provincial departments of health organize family planning clinics in each public health unit to ensure that everyone has access to information, medical assistance and birth control devices and drugs as needed. At its annual meeting in June 1971, the Canadian Medical

Association recommended that advice and assistance on family planning be made readily available to all residents of Canada as a means of preventing unwanted pregnancies which lead to demands for abortion.

These developments led Mr. Munro to seek cabinet approval in the autumn of 1971 for additional manpower and financial resources, including direct grants to provincial and non-governmental agencies. Impetus was added by the findings of the Special Senate Committee on Poverty<sup>7</sup> in relation to family planning and the poor. It cited evidence that poor families want the same number of children as the better-off but practice family planning much less frequently. It expressed concern about the apparently limited use by the poor of family planning services and recommended that family life education, family counselling and family planning programs be made available and easily accessible to them. Mr. Munro was consequently able to announce on November 18, 1971 at the annual Meeting of the Family Planning Federation of Canada that the government had decided to ask Parliament for additional manpower and money for family planning purposes through supplementary estimates for the current fiscal year and for the inclusion of further resources for the same purposes in departmental estimates for the fiscal year commencing April 1, 1972.

On the same occasion Mr. Munro announced that his department would organize the First National Conference on Family Planning to be held in Ottawa in February 1972. Invitations would be issued to provincial authorities, professional associations, religious bodies,

citizen groups and other interested organizations. He described the conference as a forum in which to assess progress in development of services and to consider how public and voluntary organizations can cooperate effectively to improve family planning programs.

Up to this point the federal program had been coordinated through a committee chaired jointly by two assistant deputy ministers -- one on the Health, the other on the Welfare side of the Department -- with the writer as secretary. This arrangement proved administratively unwieldy and time-consuming. Any communication upward to the deputy ministers had to be cleared with both co-chairmen. Similarly any communication with the Minister required the signature of both deputies. It was therefore decided to bring total responsibility for the family planning program under one deputy minister. Because social welfare concerns were considered to be of primary importance in implementing the federal program, it was made the responsibility of the Deputy Minister of National Welfare, then Dr. J.W. Willard. In January 1972 Dr. Robert W. Tooley who had played a leading role in the development of the program from the Health side, was appointed the first Director of Family Planning, immediately responsible to Dr. R.B. Splane, Assistant Deputy Minister, Social Allowances and Services.

The First National Conference on Family Planning was action oriented. It was designed to produce practical recommendations for action by the various interests involved. A drafting committee, from which government representatives were deliberately

excluded, consolidated the findings and recommendations of discussion groups. The committee produced five broad statements of principle and 22 specific recommendations which were endorsed by the final plenary session.<sup>8</sup> The only serious disagreement arose out of a recommendation that the full spectrum of family planning services should include abortion. This view was sharply opposed by "pro-life" groups and a motion to delete it was defeated by a narrow margin.

The Department of National Health and Welfare later appointed an internal task force to examine the recommendations in terms of their feasibility for implementation. The task force commented on federal programs and policies as they related to specific conference recommendations. Copies of the recommendations were sent to the appropriate provincial, territorial and municipal jurisdictions and to many non-governmental agencies and organizations. The general principles and conference recommendations, together with comments of the Department task force were published in booklet form. The demand for it has required several reprintings.

Early in 1972 the Family Planning Division began to acquire staff, to work out the details of its program and to evolve the necessary administrative procedures. Mrs. Cenovia Addy, who had carried major responsibility for the organization of the First National Conference, became the Division's Social Service Consultant, while the writer became its Principal Program Officer, responsible for the everyday administration of the grants program. Provision

was also made for a Community Education Consultant, a Nursing Consultant and a Resource Centre Officer, as well as support staff.

For the purposes of the federal program, family planning has been defined as the knowledge and practices that enable couples to avoid unwanted pregnancies, bring about wanted births, regulate the interval between pregnancies, control the times at which births occur in relation to the ages of the parents and to decide the number of children they wish to have.

The official objective of the program is to ensure the accessibility and availability of family planning services to all Canadians who want them. Four methods of achieving this objective are outlined. The first is by informing Canadians about the purpose and methods of family planning, so that the exercise of free individual choice in this area will be based on adequate knowledge. The second is by promoting the training of staff involved in family planning services. The third is by promoting relevant research, while the fourth is by aiding family planning programs operating under public or voluntary auspices through federal grants-in-aid and joint federal-provincial shared cost programs.

Four major program activities are designed to achieve its objective. Consultation in matters relating to family planning are provided to other units within the Department of National Health and Welfare, other federal agencies, provincial, territorial and municipal departments of health, education and welfare, to universities and colleges and to a broad range of non-governmental organiza-

tions. Informational-educational materials on family planning, family life and sex education are provided in quantity, free of charge, through the Family Planning Resource Centre. Divisional consultants may be made available to assist in the training of health, welfare and education staff working in family planning. Family planning grants are available for the financial support of family planning services and for demonstration, training and research projects.

Three major considerations have helped to shape federal policy in this field. First, since family planning involves emotionally charged behaviour in an area traditionally regarded as private and personal, the government must avoid even the appearance of telling people what to do. For this reason federal authorities have emphasized that the program has no demographic objectives and that it is designed to enable Canadians to make free and informed choices about the number and spacing of their children. Secondly, since the institutional means of implementing the program are largely controlled by the provinces, through their departments of health, welfare and education, the federal government cannot command their participation. Thirdly, voluntary agencies have an important part to play in identifying family planning needs and developing means of meeting those needs.

The federal operation has consequently evolved in close cooperation with the provinces. They are consulted in the process of creating new informational material and become major consumers

of it. Formal channels of communication have been established with the provinces as part of the administration of the family planning grants program. It is standard practice to refer project applications for provincial comment before a federal decision is made. In some cases the province undertakes to maintain a service that has proven its worth during an experimental period supported by federal grants.

Voluntary organizations are eligible for support under the family planning grants program. The first and major beneficiary has been the Family Planning Federation of Canada. With the help of substantial annual grants it has, since 1972, developed active affiliates in every province and territory in Canada. These provincial affiliates have helped to achieve one of the priorities of the family planning grants program -- the holding of broadly based provincial conferences designed to identify family planning needs and to make recommendations for action. Since such recommendations are likely to be directed mainly to the provinces and one territory. At the first of these, which was also the founding conference of the Federation Quebecois pour le planning de naissance a senior official of the provincial Ministry of Social Affairs made a major policy statement.<sup>9</sup> The Ontario Conference, sponsored by Planned Parenthood Ontario and held in October 1974, was instrumental in producing a policy statement by the Minister of Health in December of the same year.<sup>10</sup> A provincial task force has been studying family planning issues for some time.



Because it is not directly responsible for the provision of family planning services, except in relation to some native peoples, the federal government has been less directly involved than the provinces in some controversial areas of public policy. These are politically sensitive because they involve sexual morality. The continuing decline of the crude birth rate in Canada over the past few years suggests that the majority of Canadians are voluntarily and successfully controlling their own fertility. Public opinion polls indicate that Canadians generally favour the ready availability of the necessary information and services. However, the provision of such services to unmarried persons, especially teen-agers, is a contentious area. Those who frown on sexual activity outside marriage tend to disapprove of contraceptive services for single persons, particularly the young and unmarried, and widowed or divorced females.

The problem is sharpened in relation to unmarried youth because the age of consent for medical treatment without parental consent is under provincial jurisdiction. That age currently ranges across Canada from 16 to 18 years. Some concerned parents fear that providing easy access to family planning services will encourage immorality among children. However, studies of clinical services used by teen-agers indicate that most of their clients were sexually active or had decided to become so before requesting service. It is consequently argued that seeking protection against an unwanted pregnancy constitutes responsible sexual behaviour on

the part of the young people concerned.

Another problem area for the provinces is sex education in the schools. While the majority of parents appear to favour the inclusion of such material in school curricula, a minority is vigorously opposed. Some fear that sex education will encourage "immorality" in their children; others see it as an intrusion upon their authority. In the writer's opinion this conflict is artificial. There should be no question in principle as to whether sex education should be given in the home or the school. Both are essential. Children's sexual attitudes are shaped by the parents, consciously or unconsciously, before the children enter the school system. Many parents need help in becoming comfortable with their own sexuality as a basis for free communication in this area with their children. Such parents often welcome the development of sex education in the schools. In summary, the roles of the home and the school in sex education should be complementary, not competitive.

Provincial family planning programs are, not surprisingly, at different stages of development across the country. Quebec was the first to announce a comprehensive policy in 1972. It has used federal family planning grants and its own funds to introduce sex education courses at the senior levels of the secondary school system and to develop family planning services for adults. In December 1974 the Ontario Minister of Health announced that his department would take primary responsibility for a comprehensive program designed to provide information, education and services,

readily available and easily accessible to individuals who wish assistance in conception control and family planning. The province allocated \$2 million to this program for the 1975-76 fiscal year. In April 1975 the Ontario Minister of Education, the Honourable Thomas Wells, announced new guidelines for sex education in Grades 11 and 12.<sup>11</sup> Mr. Wells recognized the political sensitivity of the area in stating: "It's almost inevitable that a mere mention of the term 'sex education in the schools' causes many people to worry, sometimes quite vocally." He said he was not questioning the sincerity "of those who feel that some of the topics should be covered at home exclusively and not at school. But I think we have our heads in the sand if we stand back and blithely say to ourselves that the schools have no role to play."

Saskatchewan has appointed a full-time family planning coordinator in its Health Department and the government has under study reports of two committees, one on family planning to advise the Minister of Health, the other on family life education, to advise the Minister of Education.

Since 1967 Alberta has made public funds available, through its Preventive Social Service Program, in support of family planning activities. The province contributes 80 per cent of operating costs of projects conducted or approved by the municipalities when the latter agree to contribute the other 20 per cent of costs. The provincial Department of Health and Social Services has a family planning coordinating committee. It also maintains a full-time nurse

consultant and a part-time medical consultant in family planning whose activities were supported for the first three years by a federal family planning grant.

British Columbia is moving to take over responsibility for the operation of a number of family planning clinics first established by the Planned Parenthood Association. The Nova Scotia Social Service Department published guidelines in January 1974 for its staff relating to the provision of counselling and referral services in family planning<sup>12</sup> and sponsored a series of staff training seminars with the help of a federal family planning grant.

The abortion issue continues to haunt the federal government because it is a matter of criminal law. As already noted, controversy erupted at the First National Conference on Family Planning in 1972 over the question of including abortion in the full spectrum of family planning services. "Pro-life" groups also criticized the comment on this item by the departmental task force appointed to review conference recommendations, which reads as follows:

Although the federal government does not regard abortion as an acceptable method of primary birth control, it is recognized that, since no contraceptive method now available is completely reliable, and since contraception is often used ineffectively or not at all, unplanned pregnancies are inevitable. Provincial and municipal governments and voluntary agencies providing family planning services may therefore consider that there is a place for post-conception fertility control within the limits currently imposed by the Criminal Code, and that their programs should include abortion counselling services.

Consistent with this position, both Mr. Munro and the Honourable Marc Lalonde, the next Minister of National Health and Welfare, recognized abortion counselling as a legitimate secondary activity of family planning services supported by the Department when such counselling includes all the alternatives legally available to the woman.<sup>13</sup> The family planning grants program does not provide support for organizations whose primary function is counselling around unwanted pregnancies or advocating either the liberalization or the stiffening of present provisions of the Criminal Code relating to abortion.

During a discussion of Departmental estimates for the 1975-76 fiscal year before the Commons Committee on Health, Welfare and Social Affairs Mr. Lalonde made clear his own views about the relative responsibilities of the federal government, the provinces and the voluntary sector in the family planning field.<sup>14</sup> He emphasized that primary responsibility lies with provincial health, welfare and education agencies and that the federal government is contributing extensively to their programs. In health it is through medicare and hospital insurance, in welfare through the Canada Assistance Plan. Federal funds also go into post-secondary education. The federal government must be careful not to usurp the responsibilities of the provinces, but to cooperate with them and with the private agencies, acting as a kind of catalyst. Federal financing of voluntary organizations such as the Planned Parenthood Federation of Canada and Serena encourages them to provide leader-

ship and action at the grass-roots level across the country.

As Mr. Lalonde indicated, the major cost sharing mechanism in welfare is the Canada Assistance Plan. This program is being modified so as to increase its potential for the support of provincially operated or approved family planning activities. Under present legislation federal aid cannot be provided to social services which are universally available without reference to economic need of the consumers. Legislation is being prepared, in consultation with the provinces, which will permit federal sharing of the costs of some social services, including family planning, if the province wishes to make these universally available without charge.

The 1974 policy statement of the Canadian Association of Social Workers<sup>15</sup> is consistent with the federal view that family planning is, in practice, the voluntary control of fertility. That statement also holds that governments have a responsibility to assist people to achieve this objective. At the beginning of 1976 only Canada and two provincial governments (Ontario and Quebec) had explicitly accepted that responsibility. In the writer's view, a priority for social workers in other provinces is to ally themselves with other concerned professionals and citizens groups, such as planned parenthood associations, to persuade the provincial authorities to accept their responsibility unequivocally. The required commitment should include not only a statement of intent, but also the assignment of responsibility for carrying out that intent. Since family planning concerns cannot be compressed into the mandate of any one department of government, all interested

agencies should be represented. In Ontario, for example, an inter-ministerial committee is chaired by a representative of the Ministry of Health. Other members represent the Ministries of Community and Social Services, Education, Colleges and Universities and the Youth Secretariat. Social workers should be knowledgeable about the provisions of federal-provincial shared cost programs which are capable of supporting family planning activities within the provinces.<sup>16</sup> In the present climate of austerity provinces are understandably reluctant to incur additional expenses which they will have to bear alone. The nature and scope of the initial commitment will vary from province to province, depending on a number of factors. Once achieved, however, the basic commitment can become a lever for the improvement and expansion of the provincial program.



<sup>1</sup>Canada, House of Commons, Journals, Vol. CXIII 1966-67, No. 168, p. 1091.

<sup>2</sup>Ibid., p. 1092.

<sup>3</sup>Ibid.

<sup>4</sup>Canada, Department of National Health and Welfare, News Release 1970-105, (Ottawa: Sept. 18, 1970).

<sup>5</sup>Document on Family Planning tabled in the House by the Hon. John Munro, Minister of Health and Welfare, May 6 1971, (Sessional Paper No. 283 - 7/12A).

<sup>6</sup>Canada, Royal Commission on the Status of Women in Canada, Report, (Ottawa: Information Canada, Sept. 1970), pp. 279-80.

<sup>7</sup>Canada, Senate, Special Committee on Poverty, Poverty in Canada, (Ottawa: Information Canada, Nov. 1971), pp. 128-31.

<sup>8</sup>Appendix 2.

<sup>9</sup>Fédération du Québec pour le planning des naissances Congrès d'Orientation, Québec, 16-17 Sept. 1972, Rapport, pp. 57-72.

<sup>10</sup>Statement by the Hon. Frank S. Miller, Minister of Health, in the Legislature, Dec. 12, 1974.

<sup>11</sup>Toronto Globe and Mail, April 26, 1975.

<sup>12</sup>Appendix 8.

<sup>13</sup>Appendix 3.

<sup>14</sup>Canada, House of Commons, Standing Committee on Health, Welfare and Social Affairs, Proceedings, May 21, 1975, p. 26.

<sup>15</sup>Appendix 4.

<sup>16</sup>A summary of these provisions, Shared Cost Health and Welfare Programs and Family Planning, is available, free of charge from the Family Planning Resource Centre, Dept. of National Health and Welfare, Ottawa.

## THE NEW SEXUALITY: CHALLENGE TO VOLUNTARY BOARDS

Lillian Thomson, B.Sc. (Econ.)

Voluntary boards: what are they for? What on earth are they supposed to do about the sexual revolution or any other revolution for that matter? Why do people get involved with them anyway?

Just as Mount Everest was climbed because it was there, people are active on a board because it is there. Probably it was formed years ago when a few citizens became convinced that they should get organized to meet certain circumstances that to them constituted a community problem. Their strong convictions carried them onward to become a legal entity, incorporated as such. Thus they were forever Founders.

The founders of a voluntary organization had the satisfaction of building something that, at least to their way of thinking, was brand new. Moreover it was theirs. They could feel an innocent pride of possession. After the lapse of a century or so, their attitudes and actions may appear odd, but they illustrate the difference between the ardent labours of the founders and the uninspired functions of their successors.

### Functions, and some Problems

The functions of a modern voluntary board usually include the following:

1. Outlining the total program in keeping with the

organization's aims, maintaining different parts of the program in balance and coordination, and making decisions on curtailment, extension and innovation.

2. Taking responsibility for budgeting, for securing resources and for assuring the proper management of resources.
3. Selecting top management.
4. Making personnel policies (to be implemented by management) covering salary structure, working conditions, recruiting and staff development.
5. Informing the public about the organization's activities.
6. Being ultimately accountable for the quality and acceptability of the organization's service to the community.

It must be admitted that many board members would scan the above list of functions with scepticism. They would be well aware that program is shaped mostly by employed staff. The main sources of funds are external to the organization's activities, located in united campaigns or government bodies. Even in the selection of top management, larger organizations increasingly obtain the help of management consultants. While many boards

develop personnel policies and public relations programs, they may do so with an uncomfortable feeling that they themselves are in no position to assess the quality of the service and its real impact on the problems of the community. They must depend on reports from management, on their general impressions and, where these are available, on evaluations made by regulatory or standard-setting bodies. They may feel that they are committed to goals that were not of their making, with circumscribed power in the crucial area of funding and with limited self-confidence in program planning. It is not surprising that interest sometimes becomes half-hearted. Inertia sets in.

Nothing will disperse inertia faster than a challenge that is genuine because the issue is both serious and controversial. The new sexuality is creating more than one such issue, because out of this trend in society arise such debatable questions as the well-being of youth, abortion, access to contraceptives and the protection of infants.

### The New Sexuality

A few board members, tired of the world's crazy ways, may argue that the notion of a new sexuality is just another gimmick of the media and that there's nothing new about sexuality. Of course they are right in the sense that sexuality has been a feature of human existence in history and pre-history and they are right if they imply that the secrecy about human sexuality that characterized

the last century did not diminish sexuality but merely reduced its visibility. They are under-reacting, however, when they assume that there is nothing new about sexual relationships today and therefore nothing that should concern a sensible board of directors.

New in human experience is contraception by the means made available through modern technology. Like other inventions, for example television, resources for contraception mean changes in habits and life styles. People adjust or re-affirm their values in response to this tremendous extension of human knowledge with its powerful impact on human relationships.

But although change is in progress it is far from total. Many people assume that the Victorian attitude toward sexual expression is in disrepute and the taboos of the past forgotten. In fact, puritanism still has strong roots in the culture of this part of the world. Even the overt preoccupation with sex, which is one of the most obvious features of society, may be due in part to a failure to escape from the Victorian mold. It might be supposed that greater openness and security in sexual activity would have freed people to be less preoccupied with sex, somewhat as greater confidence in the availability of a food supply seems to have released some societies from a stressful concentration on survival. Actually, North Americans seem obsessively concerned with sex. Members of helping professions can testify to the number

of persons who are thoroughly confused as they struggle to escape from the sexual confusion of their formative years.

If endless printing and incessant talking could guarantee well-educated readers and listeners, then people who are living today would be educated regarding sexuality beyond any other people on any other subject. As most people realize, however, knowledge is exploding. It flies past swiftly and in fragments. Notions of human sexuality are apt to be shallow. Knowledge is apt to be incomplete because it was acquired in bits and pieces from specialized examination of parts of the whole subject.

For board members who are obliged to make some sort of sense out of conflicting evidence and opinions, what is devastatingly apparent is that they cannot expect agreement on this subject. Until recent years, people expected agreement on moral issues at least within their own economic class, their church, family or age group. Consensus is no longer to be expected, especially in a board that is mixed as to life experience, age and education. In 1975 most newspapers got some mileage out of a television interview with Betty Ford, the wife of the United States President, who said that premarital sexual relations with one's chosen partner might prevent marriage breakdown in some cases.<sup>1</sup> The opposition was led by the president of the National Federation of Republican Women, Constance Armitage, who advocated "encouraging this generation to have the morality and standards which have served to make the

the family a core from which one can build a sound, respectable civic organization, order in the streets, and from which our leaders evolve."<sup>2</sup> These two distinguished women illustrated the diversity of opinion and cross-purposes to be found within most groups of citizens in the 1970s. A YWCA-YMCA study commission puts it this way: "Census among groups of individuals is less and less readily achieved and this is, of itself, a current social phenomenon of considerable consequence".<sup>3</sup>

Here, then, is the board of a voluntary agency--an agency in the business of helping individuals and families on questions of social relationships and in a society that for the first time in human history not only possesses dependable contraceptives but also has only partially changed its attitudes to sex, on the whole is poorly informed on sexuality and as often as not is without models of conduct or ethical consensus that might help people find satisfactory patterns for their sexual experience. It is under such circumstances that a voluntary board encounters a number of issues related to sexuality. They are issues not to be evaded.

#### Family Planning

If family planning is important to the people served by an agency, then it is important to the board and staff. Presumably any modern board would agree unanimously that the responsibilities of family life include responsible planning of family size. One organiza-



tion will differ from another about acceptable methods of birth control, but this fact only emphasizes the need for each organization to be clear regarding its viewpoint.

What can never be assumed is that the idea of family planning will be integrated into the traditional work of the agency. When people are planning policies and programs, do they readily and naturally identify family planning as one of the essential ingredients in any program for preventing marriage breakdown, unsatisfactory child rearing, or poverty? For example, in Ontario's Hanson Report<sup>4</sup> more than a dozen services are identified as being needed for family support but family planning is not among them. The same observation could be made regarding many documents in the welfare field. For people who recognize family planning as crucially important in family and community life, and indeed in world affairs, the omission is serious. It is also significant that people are still thinking in patterns they established before the technological revolution. In the welfare field there is plenty of dialogue about social change and adaptation but the people in the field find it just as hard as anyone else to get into their very bones the implications of change.

Even if the board's viewpoint is well-informed and well-related to current conditions, how is that viewpoint expected to influence agency activities? Since these activities are normally carried on by staff members, the board's understanding of staff

responsibility becomes important. It is at this point that boards may be weak. On some boards there may be a few members who take it for granted that they know how social workers work and yet who display ignorance of the basic ideas of social work. The fault may lie in a haphazard selection or election of board members, or in the fact that administrators so often perceive board activities as a cumbersome chore. Board activities can conceivably be regarded as a potentially fruitful program in community development. On a subject such as the new sexuality, board discussion is more likely to produce genuine challenge and constructive response if the members have some insight into the principles that guide the work of the agency and can relate the specialized subject to the whole range of service. Board orientation and board-staff conferences should allow time for explanations and arguments regarding the basic philosophy and principles of social work. In spite of the range and diversity within social work practice, it should be possible for board and staff to engage in mutually beneficial discussion of a question such as: "In social work, what do we mean by the dignity of persons?" People with any grasp of the principles of good social work could never imagine that social workers are, for example, bustling men and women into medical consultation against their will or obliging them to adopt birth control measures on pain of losing financial or other benefits.

The board of a voluntary agency owes it to the community

and especially the staff to clearly state the agency's policy on family planning if the subject is in any way related to its work. A policy statement should define what the agency means by the term "family planning." It should sanction staff activity along lines of good social work practice in helping people to make their decisions regarding family planning and in finding appropriate community resources. It should provide for flexibility in relation to any staff member who may, for any reason, have reservations about participation in interviews on family planning.

The board has a right to be assured that staff members have access to current information on birth control methods and resources. They may recommend that this field of knowledge be included in staff development seminars. They should not assume that staff members are knowledgeable in these areas. While few staff members would expect to be a primary source of information, except possibly on community facilities, their information should be accurate and up-to-date as a basis for intelligent conversations with men and women who have a right to expect helpful consultation.

What about under-age boys and girls? For those who are sexually active, should the means of contraception, or information about the means, be provided? Board and staff should clarify their thinking on this question. Staff members must know the agency viewpoint for purposes of counselling parents and for supervising children in care. It is the responsibility of the

board to decide and to state clearly whether or not the counsels of the agency are available to all persons regardless of age, sex or marital status, with due regard to provincial regulations on age of consent or other regulations. In service to a minor, the ideas and feelings of parents, if they are interested, might be decisive or might be the starting point for counselling. Some parents resist outside influences on this subject. Other parents are strongly determined to secure all possible protection and advice for their children. If the agency itself is the guardian, it takes counsel with itself as to how its policies, set by its board, can most usefully serve the young person.

What are the wishes of a boy or girl who is affected by a decision more than anyone else? Too many young persons, the subjects of concern in social work establishments, are never consulted in ways that would open up real communications with them. Some agencies address themselves to parents and never get to know the children and young people in families. The fact remains that the young person is indeed the person mainly concerned. It is not to be taken for granted that a young person would want to avoid pregnancy or to be protected by preventive measures. Not much of anything can be taken for granted except one thing: teenagers have a lot of growing-up to get on with. Counselling on the specific subject of contraception, if it is undertaken, should be

kept firmly within the broader context of the whole growing-up process.

What about younger children? How does the agency meet the needs of a promiscuous, seduced or raped 12-year-old? Highly sensitive counselling is of course required for the child and the family and there may be special problems if neighbourhood or community controversy arises. It may be the kind of situation that invites publicity. In this case, it is a fortunate administrator who can rely on sound advice from the board and who can depend on the board to give first priority to the interests of the family and second priority to the task of representing the agency to the public.

It is worth repeating that it is essential for a board not to be in the dark as to the principles that make for sound service. A sudden storm of controversy or some other crisis merely underlines this continuous necessity.

#### Counselling Regarding Abortion

Counselling regarding abortion confronts boards of directors with a different set of problems. Here is perhaps the most controversial issue in communities today. Almost every board is bound to reflect within itself the dissension within the community at large.

Let it be said immediately that conflict of opinion within a board need not be a disaster; it can greatly strengthen the board and the organization. Without it, board meetings can be

stupid. To produce worthwhile results, conflict does require special skill in chairing, in debate and in staff support. Many a board member can testify that there is nothing like a burning issue to enlarge one's education on the conduct of meetings and on human nature.

Debate may be sharpened and yet its heat reduced by attention to a few practical points:

1. The term "abortion counselling" is often carelessly or perversely interpreted to mean counselling in favour of abortion. Board members should be clear that so far as they are concerned the term means counselling in accordance with sound social work principles that touch upon the client's consideration of abortion as an acceptable or unacceptable solution to a problem.
2. A board member should possess accurate information on the law regarding abortion and should be assured that staff members are accurately informed.
3. Boards of directors have the right and sometimes the duty to support, criticize or protest abortion laws by presenting their considered opinions to legislators.
4. In any agency in which staff may be expected to counsel people who are considering abortion, the board has an inescapable responsibility to formulate unambiguous

policy that will apprise staff and clients of the agency's intentions and provide agency support and protection for staff practice.

The question of abortion is so controversial that a board probably cannot make a decision acceptable to all its members. Nevertheless under no circumstances should a board evade its responsibility by tabling the matter or procrastinating. The bylaws or rules of order call for majority decision or some other basis for the adoption of policy, and should be followed. A member who has scruples about being party to the agency policy (on principle as distinct from mere disagreement about methods of work) has the right to resign and should exercise the right, if possible without rancour, unless he or she feels it would be more constructive to remain on the board in the hope of continuing to influence other members. Policies made by the board can be unmade, amended or reversed. If there is a resignation the majority voters, if they are wise, will accept it respectfully as being the result of mature judgment. There is a tendency to feel guilty in the face of a resignation due to disagreement and to try to make adjustments that will prevent an obvious break-away. In "the good old days," a voluntary board was a fraternal club in which sensible people reached a comfortable consensus; now, although many people would like it to remain so, it cannot be kept that way. The best that can be done in some situations is for the majority



to reach an honest decision and to assume that those who disagree have done the same.

A peculiar situation has been appearing in some boards (usually of hospitals or social agencies) when an outside group plans for selected citizens to be elected to these boards in order to influence the institution's position on abortion along lines advocated by the outside group. This is the strategy of infiltration.

To begin with, there is nothing illegal or immoral about any group of citizens taking steps to improve, as they see it, the services of a community agency. The group may be over-zealous or cranky or over-reacting to the merit or evils of the new sexuality but after all, any citizens or citizen groups presumably have the privilege of taking an interest in a voluntary community service. Moreover, if an agency has a strong constituency, if its aims are known and respected, and if its board is elected from a sufficiently wide community base by open procedures, it has not much to fear from infiltration. Unfortunately in some voluntary organizations board members are rounded up haphazardly at the eleventh hour by non-too-interested current members. These agencies get the kinds of boards they deserve and would be all the better for infiltration from almost anywhere.

Attack or pressure from without may jolt the board into taking a fresh look at the problems of the people they claim to be

serving. There are stereotypes to be discarded. For instance, it is surprising how many people talk as if only unmarried girls are candidates for abortion counselling. Actually a married women may be the one with the most painful dilemma, and a prospective father, married or single, may be as bewildered as anyone else when abortion is considered. The responsible board keeps in mind a comprehensive picture of agency service and the needs of the wide variety of people likely to be served by a modern agency.

Another serious problem has appeared: the financial support of an agency may be threatened because of its stand on abortion legislation or counselling. The threat may emanate from the establishment that supplies funds or it may be directed at the funding body with the aim of forcing it to withhold funds from a particular agency.

During a period in which an agency is developing its official policy on a subject on which public opinion is already divided, the board would be well advised to consult with funding bodies and close colleagues in the field, not in order to be decisively influenced by them but rather to explain the trend of the agency's thinking and to get the benefit of their reactions and experience. Later, their prior understanding of the agency's thinking may be vitally important.

If trouble comes in the form of aggressive opposition to the agency and its policies, the board should stand firm on a

position that it adopted in good conscience. The integrity of the organization's ethos and purpose is more important than the size of its budget or even than its continued existence.

When under attack, the board should open up or keep open lines of communication with other organizations. A threat to one organization is likely to become a threat to others. In fact, the board should make sure that the whole community is told what is happening. The media usually will report a controversial issue or event. In cities where there are united funds and planning councils it would be appropriate and probably advisable for these bodies to provide a forum for inter-agency communication.

A member of a voluntary agency's board has a front seat for observing the customs and values of society. Trends can be traced at conferences and in popular and professional literature. For example, among a half-dozen discernible trends in the human services today is the trend toward freedom of choice, the right to participate in choice of treatment and the increasing acceptance and exercise of this right.<sup>5</sup> It is in making choices that people may be looking for counsel. What are likely to be the long-term as well as the immediate consequences of a choice? Does one make a decision with exclusive reference to one's own interests or convenience or with reference to others in one's network of human relationships? There are among the ethical questions that confront the person and counsellor.

Social service organizations with substantial experience in providing services to troubled persons may be said to have a special obligation these days to make themselves available to people looking for objective counsel. There are plenty of groups whose counsel may be depended upon to reflect the passionately held convictions of the groups themselves. Many people would like to feel that somewhere they can secure unbiased counsel.

#### Child Parents and Their Children

Today, (especially in the child welfare field) there is widespread anxiety about the welfare of children in the care of mothers in their early or middle teens and there is equal anxiety about the young mothers themselves. The average age of unwed parents is lower than formerly and an increasing percentage of single mothers retain custody of their children. In Ontario, nearly half of the pregnant unwed girls who come to the Children's Aid Societies for help are 17 years of age or less and 73 per cent of them are in their teens. Some 60 per cent of them choose to raise their children themselves. There is a growing impression that the younger the mother, the more likely she is to want the custody of her child. She may still be in the doll-dressing stage of girlhood or want status among her friends or consider that her chance of marriage would be better. The social assistance that she can claim may look meagre enough to an older person and yet appear to be a fortune to an immature girl with no knowledge of housekeeping. A

serious handicap for the very young parent is the plain fact that infancy and early childhood are brief. A teen-age girl, if she has no clues or models to start with, can't learn to be a good parent fast enough for it to make much difference to her child.

Although within an agency serving under-age parents the immediate responsibility naturally falls on the staff, the board also has responsibilities. Unfortunately these responsibilities are too easily set aside because they lack the urgency of direct service. The following matters should come before the board:

1. The board should be fully aware of the incidence of under-age parenthood and should know whether statistics indicate an increase or decrease. It should know what percentage of immature mothers are retaining custody of their children past infancy. Research is crucially needed on this development in today's society. Long-term research is needed and this fact immediately poses a problem because so much of the scanty social research in Canada is financed for periods too short to comprehensively study trends that can be evaluated only with the passage of years.
2. Boards should give strong support to research efforts and, unless they are satisfied that sufficient research on a particular area is under way, they

should make social research bodies aware of the need for it.

3. Boards should review the law and regulations, or absence thereof, pertaining to under-age parents and hear some of the proposals being made regarding the protection of the children of minor unwed parents.<sup>6</sup> It should be remembered, however, that the children of unmarried parents are not the only children in jeopardy. Children of immature parents--married, separated or divorced at an early age--may be at great risk. All of these young families, whether or not the parents have ever been married, should have access to the basic community resources of good day care and homemaker services. In addition, organizations need all the imagination and innovation they can muster to try out new styles of foster homes for mothers and children, group homes with adult supervision, commune-style group living, co-op residences, and family camping.

Probably it would be true to say that an agency encountering new problems of youth and needing new solutions would be better prepared if its board included younger as well as older members, and also if its projects and experiments were designed to emphasize self-help and self-direction. Thomas H. Walz,<sup>7</sup> speaking

of the segmented family, questions arrangements in which "likes" interact with "likes" and increasingly ignore others. He claims that the absence of differing age groups, could be the single important weakness of many newly-evolving family and para-family structures.

It may occur to some board members that some of the time being spent on sex education might profitably be spent on education for child-rearing. Other countries, such as the People's Republic of China, have found ways of enabling secondary-school students to acquire practical experience in child care in the school system and in day nurseries. It should not be impossible here.

Yet sex education, or rather education in human sexuality, is critically important. The emerging generation of the 1970s is growing up in a society that has traded its former fears of sex experience for fears of the unhealthy effects of a lack of sex experience. There is heavy social pressure on youth to acquire credentials in respect of sexual competence. The impressions and notions that constitute some persons' total sex education are picked up from films and television at their most shallow levels. The social institutions including the voluntary social services should be clearer and louder about what they know to be true: that there is more to sexuality than techniques and more to sex education than diagrams of reproductive organs, venereal disease prevention or the methods of pregnancy prevention.



### Trends and their Sources

Has the new sexuality got much to do with these developments and trends in services to families and youth? There are people ready to claim that the problems are all due to "permissiveness"---a jumble word usually applied in a disparaging sense to indicate anything from negligent parenting to promiscuous sex relationships. Some people equate the new sexuality with permissiveness, using stereotyped definitions of both words. The trouble with stereotyped thinking lies in its failure to recognize that social customs, attitudes and problems have multiple sources. Many circumstances today are changing the needs of children and youth and calling for change in services.

Any serious analysis of services to children and youth will take into account the established fact that young people are reaching puberty at an earlier age--a trend that is still continuing. There is also the already mentioned preoccupation with sex that permeates this society. Children experience erotic stimulation that would have been unthinkable in an earlier generation. They can scarcely be blamed for imagining that they know all about sex because they have heard and seen so much, although what they have heard and seen may be scrappy, misleading and totally devoid of any sense of depth in human relationships. A third factor is that youth is guided by youth. It is natural in the growing-up process for young people to separate from parents and from strong ties with

peers. In North America the influence of the peer group is tremendous. There is some evidence that it is more so on this continent than in other parts of the world.<sup>8</sup> Does this mean that youth has unprecedented reasons for rejecting close relationships with parents? Does it suggest increasing disengagement on the part of parents from the tasks of child rearing?

A fourth factor is the apparently changing perceptions of women in relation to sexuality, together with a change in the degree of importance attached by society to fertility and procreation. Woman's former condition is brilliantly caught by feminist Germaine Greer in her phrase "the female eunuch."<sup>9</sup> The condition is changing as sexual activity comes to be appreciated as a normal function to be enjoyed by women as well as men. With this insight come rising expectations of happiness. Sexual partners hope to please each other. For some, the old fears of unwanted pregnancy are replaced by new anxieties regarding their sexual capabilities. It is a time that invites thoughtful couples to take a second look at the meaning of personal freedom and to recognize in the emotional life, as it has long been recognized in political life, that freedom is not in itself an ultimate goal but rather a condition under which people are better able to understand themselves and their partners and to achieve mutual happiness.

Poverty is another factor, and an ugly one. What joy can the new sexuality possibly bring to a person caught in poverty--a

person with the sense of failure that poverty implants, with the fear that poverty today is something from which there is no escape, with the squalid housing that forbids privacy and dignity in human relationships, with low self-esteem in a competitive society and with little respect for parents, not because they have been bad parents but because they, too, represent failure. Board members should be especially concerned about knowing whether the risks of poverty are greater for girls and women. Certainly the statistics are not reassuring. An analysis by economist David Ross of the composition of poverty in Canada reveals that "female-headed families constituted 13.2 per cent of the total low-income families in 1961, but 28.7 per cent in 1973. Moreover, this percentage has almost doubled since 1967 alone. This increase can only partially be explained by there being more female-headed families, since female-headed families as a percentage of all families only increased from 7.8 per cent in 1961 to 8.6 per cent in 1973."<sup>10</sup>

Under all of these circumstances, can the voluntary agency offer any guidance to people who are trying to find their way? Can it help people to explore the meaning, for them, of the new sexuality in the midst of the prevailing consumer society with its priorities already fixed upon competition, economic growth, affluence, convenience, and entertainment? The answer is yes, but only on condition that the voluntary agency is prepared for

change in its structure and relationships and on condition that board members are the kinds of people who are prepared to invest themselves in their community.

Regarding agency structure, pressure seems to be building in favour of less formal, less hierarchical structures. There is an urge, if the way can be found, to narrow the gap that has been separating the policy-making board from the service-oriented staff and from the clients using the services. Ralph M. Kramer, writing of the future of the voluntary service organization, predicts a continuation of conflicts of opinion throughout society. He urges the need for voluntary agencies to have more adaptable, flexible and open democratic structures, with more use of temporary problem-solving systems.<sup>11</sup> In another article, Ruth Fildale contends that the structure of the voluntary agency is no longer as logical as it once was and that there is urgent need for a conscious review of current agency purpose, its accountability and its structure. She argues that board, staff and clientele all have vital contributions to make in shaping policy.<sup>12</sup>

An organization is in a better position to serve a society of which newness is a feature if the form of organization is flexible and if the participants--planners, managers, staff, users--are prepared to encounter change, to move together in new directions and, whenever possible, to work with other groups and fields of service. Therefore the calibre of board member-

ship is of paramount importance. Mollie Chadsey, a former president of the YWCA, sets a high standard for board members when she calls on them to be people "with skills and the willingness and ability to upgrade them. People with intellectual curiosity to want to know always more about the world around them and what makes it tick. People who can find those new areas of need and create new programs to meet them. People who are not afraid of new places or faces. People who can produce a balanced diversification and who have the ability to consolidate as they go."<sup>13</sup>

Today's voluntary organization is operating in a community in which many individuals feel that they are powerless to influence events around them, however much they may deplore what is happening. They haven't much use for social institutions--political, educational or philanthropic. They don't know how to solve world problems and they suspect that nobody else does. They are wide open to the influence of individuals and groups who see human nature as basically animal and inevitably violent.

For the board member who is tormented by just such gloomy reflections, a word of reassurance comes from a distinguished micro-biologist René Dubos. He tells us that sexuality is indeed an expression of animality but, sublimated, it can add profoundly to the quality of life. In his opinion one of the peculiarities of humankind is the power to deliberately change its habits, goals

and social structures. Genetic inheritance cannot change but humans have done things that transcend their limitations. For instance, they have changed their attitudes toward the size of families in spite of the sex drive and the directives of traditional institutions. This unique ability to change gives a deeper significance to the role of counter-cultures in history. It is the counter-culture that calls attention to the need for change and thereby helps humankind to renew itself.<sup>14</sup>

To say that a voluntary agency is following traditional aims and methods should be a contradiction in terms. A voluntary agency should try to see itself as representing a counter-culture. Its role is that of a creative minority, challenging the assumptions of society's mainstream. Its role is to beckon the community in the direction of deeper realization of mutual concern and a deeper sense of what it means to be truly human.

# FOOTNOTES

<sup>1</sup>Detroit Free Press, August 11, 1975.

<sup>2</sup>Ibid.

<sup>3</sup>Commission on Co-operation Between the YWCA of Canada and the National Council of the YMCAs of Canada, The Distance Between Two Triangles (Toronto: Commission on Co-operation Between the YWCA of Canada and the National Council of the YMCAs of Canada, 1973), p. 1.

<sup>4</sup>Ontario, Ministry of Community and Social Services, Report on Selected Issues and Relationships, (Toronto, Ministry of Community and Social Services, 1974), p. 46.

<sup>5</sup>Harold W. Demone, and Herbert C. Schulberg, "Human Service Trends in the Mid-1970s," Social Casework (May 1975).

<sup>6</sup>Karl A. Marshall, "Licensing the Minor Unmarried Parent," Journal of the Ontario Association of Children's Aid Societies (October 1974): p. 11.

<sup>7</sup>Thomas H. Walz, "The Family, the Family Agency and Post-industrial Society," Social Casework (January 1975).

<sup>8</sup>Urie Bronfenbrenner, with John C. Condry Jr., Two Worlds of Childhood--U.S. and U.S.S.R (New York: Russell Sage Foundation, 1970), p. 78.

<sup>9</sup>Germaine Greer, The Female Eunuch (New York: McGraw-Hill, 1971).

<sup>10</sup>David Ross, Canadian Fact Book on Poverty (Ottawa: Canadian Council on Social Development, 1975), p. 14.

<sup>11</sup>Ralph M. Kramer, "Future of the Voluntary Service Organization," Social Work (November 1973): p. 67.

<sup>12</sup>Ruth Fizdale, "The Voluntary Agency--Structure versus Accountability," Social Casework (November 1973).

<sup>13</sup>Mollie Chadsey, "The Future of Voluntary Agencies," The YWCA Resource (June 1975): p. 1.

<sup>14</sup>René Dubos, Beast or Angel? Choices that make us human (New York: Charles H. Scribners' Sons, 1974), p. 165.



## ATTITUDES OF SOCIAL SERVICE WORKERS ON FAMILY PLANNING

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The kinds of attitudes that professionals have about family planning and sex education are, of course, important to the way in which they carry out their work in the field. It is therefore not surprising to see just how much energy and interest certain researchers have given to the study of these attitudes. Probably the best example of such in-depth research (mainly on the attitudes of medical students) is the impressive work by Harold Lief and David Reed<sup>1</sup> of the University of Pennsylvania. Unfortunately, in the province of Quebec we do not have exhaustive research to draw on with regard to the attitudes of family planning professionals, nor has there been any study of the attitudes of social workers.

Thus it is important for any family planning worker to use judgment so that no opportunity is missed during any professional activity that might provide grounds for fruitful research.

Following this line of thought and taking advantage of the fact that annual professional training sessions on family planning were organized in 1974 and 1975 under the Province's High School Information Program,<sup>2</sup> the Quebec Department of Social Affairs has tried to gather certain significant facts regarding the attitudes of these professionals. The department found it

necessary to offer the professionals in the High School Information Program additional training in family planning by making available 200 bursaries of \$200 each so these professionals could take part in 45 hours of courses provided within that program. Since the people in charge were aware that school social workers and nurses would have to cooperate closely within the multi-disciplinary student services team, it was felt from the beginning that there would be every advantage (despite the obvious teaching problems that might be involved) in creating a program that would reach both groups simultaneously. Therefore the program was developed in such a way that each of its themes would be covered both from the medical and the psychosocial point of view.<sup>3</sup> The course was arranged by the University of Montreal for the first year and the University of Sherbrooke for the second. They arranged for some 30 specialists in their areas to spend 10 full days as visiting lecturers, passing on their experience to the participants. In addition to attending these lectures, participants spent several hours in workshops and took part in activities of professional interest outside of the program. Such activities were organized by other professionals in the field; participation in these various activities gave a total of 372 professionals the opportunity to complete work for a certificate in fertility and family planning.

All sessions were subject to a two-fold evaluation: one by the university on the level of satisfaction of participants in

the session and one under the auspices of the department to see the nature of and changes in the knowledge and attitudes of participants as well as the interest aroused by the program. The report on the first sessions<sup>4</sup> shows a number of pertinent facts found on the attitudes of professionals working within the school system in the areas of family planning and sexuality.

The evaluation permitted a study of (among other things) the attitudes of 178 social service workers--both social workers and counsellors. This data allows us to propose a few preliminary evaluations on the subject by making possible certain comparisons between social workers and nurses.

With a sampling of this size, of course, we cannot claim such guarantees as are generally required by the rigorously scientific scope or strict representative nature of an exhaustive study. However, it seems that these data do meet minimal requirements in relation to their validity, pertinence and size of sample--conditions allowing the preparation of a preliminary article of limited scope.

#### Characteristics of the Group Studied

It must be recalled first of all that more than three-quarters of the professionals covered by this study were from the school system. Practice by professionals in this setting seems to be related to certain socio-economic characteristics: more than 50 per cent were under age 35 and more than 75 per cent were women. We must take care, therefore, not to consider this population of social service

workers as representative of the whole; the same holds true for the nurses. For example, when it comes to attitudes and the influence that age may have on them, we must be aware that there is a good chance here of dealing with a particularly liberal subgroup within each of these two professions. Also, since there is a high percentage of women in these professions, especially nursing, it is obvious that this cannot help but be reflected in attitudes, especially in relation to family planning. Moreover, in relation to the number of individuals interviewed the sample might be thought representative both of social service workers and nurses in the school system, this cannot be taken as so because these individuals were not chosen at random: they simply answered a general invitation given to their place of work. We will thus speak only of those individuals who took the course.

Table I on the socio-economic characteristics of respondents shows that a total of 23 persons out of the 201 participants in the session do not belong to the groups we are concerned with here--the social service practitioners (the social workers and social counsellors) and the nurses.

Table 1  
Socio-economic Characteristics of the Respondents

Age Groups	Sex		Profession		Job						
	No.	%	No.	%	No.	%					
20-24	29	14.4	Male	30	14.9	Social Worker	41	20.4	School nurse or social worker	154	76.6
25-34	83	41.3				Social Counsellor	24	11.9	Teaching	2	1.0
35-44	60	29.9	Female	159	79.2	Nurse	113	56.2	Information Officer	4	2.0
45-54	16	8.0				Sexual Therapist	7	3.5	Hospital	4	2.0
54-64	1	0.5	Did not answer	12	5.9	Other Professions	2	1.0	Others	19	9.4
Did not answer	12	5.9				Did not answer	14	7.0	Did not answer	18	9.0
	201	100.0		201	100.0		201	100.0		201	100.0

## Results

It is impossible to cover all the results of the research here: we will simply concentrate on a few questions that seem the most pertinent or on the attitudes of these professionals on certain priority subjects. These will be: premarital sexual relations, so-called "premature" sexual relations, "the pill," sterilization, artificial insemination, abortion and drug abuse as related to sex.

### Premarital Sex

In relation to this subject the first question asked was, "Are you in favour of premarital sex or against it?" The respondents were given the opportunity to justify their answer in the two questions immediately following the first one (this is important in relation to the interpretation of the answers).

A total of 86.2 per cent of social workers indicated that they were somewhat in favour of premarital sex, while 12.3 per cent preferred not to answer, and 1.5 per cent said they were against it (table 2). Keeping in mind the reasons given for their answers, we note a fairly open and liberal attitude to premarital sexual relations.

Table 2  
Attitudes of Respondents to Premarital Sex

Attitudes	Social service workers		Nurses	
	No.	%	No.	%
1) Favourable	56	86.2	67	59.3
2) Unfavourable	1	1.5	15	13.3
3) No answer	8	12.3	31	27.4
	65	100	113	100

If we compare the nurses' answers (Table 2), we see that although they have more conservative attitudes, the proportion of those against premarital sex remains relatively low, fewer than two out of 10. The differences seem fairly pronounced at first; we shall see if they remain so. In the meantime, if we could attempt an explanation with so little to go on, it might be worthwhile exploring the fact that the training of social service workers--much more than that of nurses--is centred on the principle of respecting the client's right to self-determination. Certain favourable answers might then be motivated simply by the conviction that the person must be left to decide for him- or herself.

Unfortunately, the reasons given to justify these answers are not of great use as data (Table 3) because of the difficulties



encountered in categorizing answers to this open-ended question. Nevertheless it would appear that more than a third of the social service workers taking part in the sessions (categories 2 and 6) see premarital sexual relations as part of a love relationship--perhaps an indication that this attitude is one of "permissiveness in the name of affection" as described by Reiss.<sup>5</sup> Only a quarter of the nurses, on the other hand, gave this answer.

Table 3  
Reasons Given by the Respondents to Justify their  
Attitudes with Regard to Premarital Sex

Reasons	Social service workers		Nurses	
	No.	%	No.	%
1) Because they are essential to mental health	3	4.6	5	4.4
2) Because they are part of a love relationship	6	9.2	12	10.6
3) Provided no one finds out	- -	- -	- -	- -
4) Provided the parents agree	- -	- -	1	0.9
5) For reasons 1) and 4)	- -	- -	- -	- -
6) For reasons 1) and 2)	16	24.6	15	13.3
7) For reasons 3) and 4)	1	1.5	1	0.9
8) For none of these reasons	20	30.8	21	18.6
9) No answer	19	29.2	57	50.4
10) Don't know	- -	- -	1	0.9
	65	99.9	113	100.0

Outside of the fact that neither group of professionals seems conditioned in its attitudes by either the social environment (3) or parental consent (4) no other conclusions can be drawn from this table. Must we conclude that "permissiveness in the name of affection" is the characteristic attitude of these professionals? Certain elements are missing from the answer: we

need only think, for example, of the very high rate of abstention and the high number of answers that did not fit in any category (8).

Table 4

Reactions of Respondents to the Hypothetical Case of  
Their Son or Daughter Under Age 16 Having Sexual Relations

	Social Service		Nurses	
	No.	%	No.	%
1) Do nothing	1	1.5	1	0.9
2) Tell them to stop	--	--	--	--
3) Leave them alone	--	--	--	--
4) Leave them alone, having given them information	24	36.9	21	18.5
5) Give them information	30	46.2	72	63.7
6) Bawl them out	1	1.5	3	2.7
7) Bawl them out but provide information	1	1.5	2	1.8
8) Make sure relationship with boyfriend/girl- friend is broken off	--	--	--	--
9) Don't know	4	6.2	3	2.7
10) No answer	4	6.2	11	9.7
	65	100.0	113	100.0

However, there was an additional question that pursued this subject further: "If you discovered that your son or daughter under age 16 was having sexual relations, what would you do?" The first finding is that social workers in this course would

not in the least favour a negative reaction: none expressed a repressive attitude (categories 2 to 8) while a censuring attitude (categories 6 and 7) was found in only 3 per cent of respondents. Moreover, more than 80 per cent of these participants emphasized the fact that they, themselves, would provide all the information required, while 36.9 per cent insisted on the need to respect the independence of the son or daughter.

Results are somewhat comparable for the nurses except how they see their role more at the information level (63.7 per cent as opposed to 46.2 per cent) and seem less disposed to have confidence in the young person's capacities for self-determination (18.5 per cent as opposed to 36.9 per cent). This would appear to support the same hypothesis as the previous table. These results do not contradict in any way the fact that the sexual standard these people seem to conform to is "permissiveness in the name of affection."

### The Pill

The question here was simply, "Are you for or against use of the pill?"

Social service workers taking part in the sessions were clearly in favour of the pill (93.8 per cent); only 4.6 per cent were against, only one worker was hesitant. The findings for the nurses are much more varied: 68.1 per cent of the replies were favourable and 8.9 per cent were unfavourable; 23 per cent of the nurses were reluctant to answer.

Table 5  
Attitudes of Respondents to Use of the Pill

Attitudes	Social Service Workers		Nurses	
	No.	%	No.	%
1) Favourable	61	93.8	77	68.1
2) Unfavourable	3	4.6	26	23.0
3) No answer	1	1.5	10	8.9
	65	100.0	113	100.0

It is interesting to note that the nurses, who are normally more informed about the medical and scientific factors involved in use of the pill, were more reserved and especially more hesitant in the answers they gave. Perhaps this might be taken as an indication of the merit in combining medical and psychosocial training for the two professional groups. These attitudes were measured both before and after the training session and, for this question in particular, it seems worthwhile to mention the answers given after the session because they seem to fit so well into the same statements or hypotheses: after the sessions 77 per cent of the social service workers were in favour of the pill, 3 per cent were not, and 20 per cent were hesitant.

Table 6  
Reasons Given by Respondents to Justify  
Their Attitudes in Regard to the Pill

Reasons	Social Service Workers		Nurses	
	No.	%	No.	%
1) Allows sexual relations any time	2	3.1	1	0.9
2) Does not interrupt the sexual act	1	1.5	2	1.8
3) Makes the women less dependent on the man	1	1.5	1	0.9
4) Simple method	--	--	1	0.9
5) Effective method	9	13.9	10	8.8
6) For reasons 1) and 2) only	1	1.5	3	2.7
7) For all these reasons	35	53.9	28	24.8
8) For none of these reasons	5	7.7	10	8.8
9) No answer	8	12.3	47	41.6
10) Don't know	3	4.6	10	8.8
	65	100.0	113	100.0

A second question related to the pill asked the respondents to justify the attitude chosen in the preceding question.



Since almost all these people had favourable attitudes, all answered the first question related to these attitudes. The results show without such detail that the generally recognized advantages of the pill and its effectiveness were the reasons for previous choice. Marked hesitations, presumably very real ones, are still shown by the nurses.

### Sterilization

The question on this subject was on a slightly different tack and was as follows: "Do you think that sterilization should be permanent, temporary or not allowed?"

The answers are more or less the same for the social service workers and the nurses. The professionals in both groups seem to follow the same trends of thought as the population of Quebec in relation to sterilization--at least as it is officially recognized-- and they are not restrictive at all in their attitudes (category 3). Moreover, the majority would prefer the operation to be reversible (category 2), but the poor control over knowledge in the way the question is asked probably explains why 23 per cent in the two groups cannot answer, although there is no moral objection.

Table 7

Choice of Respondents with Regard to Sterilization:

Permanent, Reversible, Not Allowed

Choice	Social Service Workers		Nurses	
	No.	%	No.	%
1) Should be permanent (total)	15	23.1	11	9.7
2) Should be temporary	30	46.1	66	58.4
3) Should not be allowed	1	1.5	1	0.9
4) Don't know	4	6.2	9	8.0
5) No answer	15	23.1	26	23.0
	65	100.0	113	100.0

Abortion

Although it is not exactly on the same level as the rest of the questions with regard to the general theme, the question of abortion is usually a clearer indication of attitudes. The question that was asked was moreover one that involved the respondent to a high degree: "If you had an unmarried daughter and she became pregnant, what would you advise her?"

Table 8  
Reactions of the Respondents to the  
Hypothesis of a Pregnant Daughter

Reactions ("I would advise her to ...")	Social Service Workers		Nurses	
	No.	%	No.	%
1) Continue the pregnancy and place the child for adoption	8	12.3	9	8.0
2) Continue the pregnancy and keep the child	14	21.5	27	23.9
3) Don't know	19	29.2	37	32.7
4) No answer	24	36.9	40	35.4
	65	99.9	113	100.0
1) Have an abortion	10	15.4	6	5.3
2) Not to have an abortion	11	16.9	29	25.7
3) Don't know	20	30.8	25	22.1
4) No answer	24	36.9	53	46.9
	65	100.0	113	100.0

The researchers thought it wise here to draw up the question in two parts and to divide the answer into two series, so that answers that dealt only with abortion could be separated,

to avoid doubt repetition in the various categories. The results show that the rates of indecision and abstention are very high--the highest of any table--and remain stable in each part of the table for the social workers, although there is an increase for the nurses when the explicit subject is abortion. The nurses also have more reservations about abortion than the other professionals (25.7 per cent against compared to 16.9 per cent of other professionals and 5.3 per cent in favour, compared to 15.4 per cent of other professionals). We conclude from this that abortion is still the question that requires the greatest involvement and evokes the most resistance. As for the future of the child if the pregnancy is not terminated, the results are comparable and do not occasion any comments.

Another study dealing with the attitudes of 227 social workers and 264 social counsellors on abortion was carried out by Stella Guy-Vallée<sup>6</sup> on behalf of the Centre de Planning Familial du Québec Inc. It required social workers, social counsellors and psychologists to take a stand on the present abortion legislation.\* For the professional categories we are concerned with here the answers were as follows:

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\*In 1969 the Criminal Code was amended to permit therapeutic abortions on the advice of a three-member hospital committee when the life or health of the woman is considered to be in danger.

Table 9

Opinions of the Professional Social Worker and Social Counsellor  
with Regard to Legislation on Abortion as of 1975

Opinions	Social Workers		Social Counsellors	
	No.	%	No.	%
1) Repeal the legislation	59	27.7	38	14.4
2) Amend the legislation in favour of a committee that would not make the final decision (decision left to the woman)	116	52.0	148	56.1
3) Amend the legislation in favour of a multidisciplinary deciding committee	32	13.0	53	20.1
4) Liberalize the legislation to integrate psychosocial aspects	3	1.1	3	1.1
5) For the status quo	9	3.3	7	2.7
6) Against abortion	6	2.2	14	5.3
7) Unclassifiable	2	0.7	1	0.3
	227	100.0	264	100.0

Artificial Insemination

When the respondents were asked whether they were for or against artificial insemination, 60 per cent of the social service workers in the session were in favour of artificial insemination while

7.7 per cent were against, 13.8 per cent uncertain or poorly informed and 18.5 per cent did not answer. Their attitudes were more favourable than those of the nurses, (60 per cent to 46 per cent), while the rates of hesitation and abstention were the same. What seems to be pointed out is that professionals have less occasion to encounter this question in their daily practice even from the nursing point of view.

Table 10

Attitudes of Respondents with Regard to Artificial Insemination

Attitudes	Social Service Workers		Nurses	
	No.	%	No.	%
1) Favourable	39	60.0	52	46.0
2) Unfavourable	5	7.7	20	17.7
3) Don't know	9	13.8	22	19.5
4) No answer	12	18.5	19	16.8
	65	100.0	113	100.0

Drug Use

The last question analyzed here was on the use of drugs in relation to sexual life: "Do you believe that the use of drugs is: 1) a counter-indication to the development of sexuality; 2) something that cannot harm the development of sexuality; 3) something that has no relation to sexuality?"

The first observation is again that a number of professionals admitted to ignorance and hesitancy regarding this topic. The rate of ignorance seems fairly high for a phenomenon that is certainly not the exception in the environment in question. There is a more closed attitude on the part of the nurses, perhaps explainable by the fact that the nurse may have less contact with student drug problems than social workers or counsellors.

Table II  
Opinions of the Respondents on the Effect of  
Drug Use on the Development of Sexuality

Opinions	Social Service Workers		Nurses	
	No.	%	No.	%
1) Drug use is a counter-indication to the development of sexuality	7	10.8	29	25.7
2) Drug use cannot harm the development of sexuality	9	13.8	4	3.6
3) Drug use has no relation to the development of sexuality	18	27.7	24	21.2
4) Don't know	19	29.2	24	21.2
5) No answer	12	18.5	32	28.3
	65	100.0	113	100.0



### Conclusion: A First Stage That Should be Further Developed

All we have done here, undisputably, is take a first step in what could become an exhaustive study of the attitudes of social workers and counsellors with regard to family planning. However, despite great limitations, it has allowed us to become aware of certain elements that are not without significance for the approach we must adopt with regard to social workers and counsellors working in the family planning field. The comparison between this group and the nurses has also allowed us to identify certain characteristics that we can definitely profit from in future sessions or in any contact with these two groups. Probably the main function of this initial inquiry, therefore is simply to emphasize the need for a further exhaustive study of this type and to indicate some of the directions it might take: the influence of such factors as work situation, age, education and sex, on the attitudes of social service professionals and, in turn, their attitudes on those of other professionals in the multidisciplinary team and on the students themselves. The influence on the professionals of their work in the family planning field, their marital status and life experience as well as short- and long-term effects of family planning training sessions might also be examined.

## FOOTNOTES

<sup>1</sup>Harold I. Lief, and David M. Reed, Sex Knowledge and Attitude Test (S.K.A.T.), (Philadelphia: Center for the Study of Sex Education in Medicine, University of Pennsylvania School of Medicine, 1972).

<sup>2</sup>See the article in this book which discusses the High School Education Program: Social Workers and Sex Education: A Quebec Example.

<sup>3</sup>See the program following of the last session organized at Sherbrooke, August 13 to 22, 1975 (no copies available for the first session).

<sup>4</sup>Quebec, Department of Social Affairs, Etude sur le stage d'information professionnelle en planification des naissances [Study on the professional training sessions on family planning] summer 1974 Quebec: Research and Statistics Branch, under the direction of Marcel M. Giner with the cooperation of Claire Villeneuve and Pierre Bouchard, DSA, 1974).

<sup>5</sup>Ira L. Reiss, Premarital Sex Standards in America (New York: The Free Press, 1960).

<sup>6</sup>Stella Guy-Vallée, Sondage sur l'avortement auprès des membres de trois corporations professionnelles [A survey on abortion among the members of three professional corporations] Montreal: Centre de Planning Familial du Québec Inc., 1972).

PROFESSIONAL INFORMATION SESSION

ON FERTILITY AND FAMILY PLANNING

August 13 to 22, 1975                      University of Sherbrooke

(Offered by the University of Sherbrooke in conjunction with  
the Department of Social Affairs)

SCHEDULE FOR LECTURES AND WORKSHOPS

Wednesday August 13

- |             |  |
|-------------|--|
| 10.00-10.30 | Opening of session   |
| 10.30-12.00 | Workshop   |
| 14.00-15.00 | Psycho-social Aspects of Pregnancy<br>Françoise Lamontagne.                            |
| 15.00-16.00 | The Sexualization Process: Birth to Puberty<br>Luc Morissette.                         |
| 16.00-17.00 | Workshop   |
| 19.30-20.30 | Physiological Aspects of Conception, Pregnancy<br>and Delivery<br>Dr. Youssef Ainmelk. |
| 20.30-21.30 | Anatomical and Physiological Aspects of<br>Pubertal Development<br>Dr. Khalil Khoury.  |

Thursday August 14

- |             |   |
|-------------|---|
| 9.00-10.00  | Puberty as a Psycho-social Experience<br>Françoise Cholette-Pérusse.                          |
| 10.00-11.00 | Psychology of Sexual Relationships<br>Jules Bureau.   |
| 11.00-12.00 | Workshop  |
| 14.00-15.00 | Initiation of an Active Sexual Life by the Young:<br>Psychological Aspects<br>Nicole St-Jean. |
| 15.00-16.00 | Fertility and Menstrual Cycle: Psycho-social Aspects<br>S.M. Husain.                          |

- |             |   |
|-------------|---|
| 16.00-17.00 | Workshop  |
| 19.30-20.30 | Physiology of Sexual Relations<br>Michel Lemieux.   |
| 20.30-21.30 | Menstrual Cycle and Specific Aspects of Anatomy<br>and Physiology<br>Dr. Willnem Pellemans. |

Friday August 15

- |             |  |
|-------------|--|
| 9.00-10.00  | Oral Contraceptives: Medical Aspects<br>Dr. Denys Cloutier.                |
| 10.00-11.00 | Oral Contraceptives: Medical Aspects (continued)<br>Dr. Denys Cloutier.    |
| 14.00-15.00 | Physiological Methods:<br>Dr. Suzanne Carreau.                             |
| 15.00-16.00 | Physiological Methods: Medical Aspects (continued)<br>Dr. Suzanne Carreau. |
| 16.00-17.00 | Workshop   |

Monday August 18

- |             |  |
|-------------|--|
| 9.00-10.00  | Family Planning Throughout the World; Two Schools,<br>Two Trends<br>Jean Tremblay.   |
| 10.00-11.00 | Family Planning in Canada<br>Cenovia Addy.   |
| 11.00-12.00 | Family Planning in Quebec<br>Yvan Richard  |
| 14.00-15.00 | Psychological Aspects of Family Planning<br>Maureen Orton  |
| 15.00-16.00 | Psychological Conditions for an Acceptable<br>Contraceptive Method.<br>Raymond Boutin.   |
| 16.00-17.00 | Film   |
| 19.30-21.00 | Serena Slide Presentation on the Anatomy and<br>Physiology of the Sexual Organs, the Menstrual<br>Cycle, Fertility and Contraception<br>Mr. and Mrs. Bertrand Allard |

Tuesday August 19

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|-------------|--|
| 19.30-21.00 | The Youth Culture and Family Planning and Sexuality<br>Robert Gemme. |
|-------------|--|

10.00-11.00	Physiological Methods: Psycho-social Aspects Denise Badeau.
11.00-12.00	Workshop
14.00-15.00	Oral Contraceptives: Psycho-social Aspects Denise Badeau.
15.00-16.00	The IUD, Diaphragm and Condom: Medical Aspects Dr. Diogène Cloutier.
16.00-17.00	Slide Presentation Michel Perreault.

### Wednesday August 20

9.00-10.00	Other Methods: Psycho-social Aspects Michel Perreault.
10.00-11.00	Other Methods: Medical Aspects and Future Prospects in the Area of Contraception Dr. Arlette Legault.
11.00-12.00	Workshop
14.00-15.00	Medical Approach to Vasectomy Dr. Denis Dufresne.
15.00-16.00	Medical Approach to Tubal Ligation Dr. Denis Lamonde.
16.00-17.00	Workshop

### Thursday August 21

9.00-10.00	Genital Infections: Medical Aspects Dr. Yvan Laberge.
10.00-11.00	Genital Infections: Psychological Aspects Dr. Jacques St-Hilaire.
11.00-12.00	Workshop
14.00-15.00	Psycho-social Approach to Sterilization Marthe Riopel-Lefebvre.
15.00-16.00	Abortion Denise Richer.
16.00-17.00	Workshop
19.30-20.30	Masturbation. Gaston Gauthier
20.30-21.30	Pregnancy Out-of-Wedlock, Premature and Unwanted Pregnancy Madeleine Potvin.

Friday August 22

9.00-12.00	Introduction to Group Training through Audiovisual Means Gilles Trudeau.
14.00-16.00	Evaluation of Session
16.00	Closing

## FAMILY PLANNING COUNSELLING: A ROLE FOR ALL WORKERS

Carmina M. Gordon, M.S.W.

One of the most serious unresolved social issues is that of unwanted pregnancies. If social workers are committed to advocacy and prevention, contraceptive counselling will be a priority.

The Report of the Royal Commission on the Status of Women states that the principal responsibility for disseminating information on birth control methods rests with health and welfare authorities. The First National Conference on Family Planning recommended that family planning services be an integral component of all community based health and/or social services. However, too frequently couples with problems of child spacing, family size or infertility have not received help from social services. When workers have become involved it has been after there were too many children, or an unwanted pregnancy had occurred.

All social workers are aware of certain common human needs that relate to family planning services. Our practice, however, takes place largely in agencies which have been organized to meet certain kinds of needs, or to serve specific groups in the population ... The active participation of social workers having knowledge in all fields of practice will be required to develop a system of family planning services to meet the needs of all kinds of people in all the current and developing patterns of service.<sup>1</sup>

Generally social workers have been reluctant to become

involved. At most we may have made a referral to a busy doctor, or a clinic where usually there was insufficient time for staff to engage the couple in a discussion of the birth control method best suited for them, or to help the woman express her fears, concerns or uncertainty about correct use. Why have we been reluctant to initiate discussion, to become involved in primary prevention by offering services before unplanned or unwanted pregnancies occur? Surely we no longer consider discussion of birth control an invasion of privacy or contravening freedom of choice. Our role is to ascertain that individuals or couples have adequate information. We do not make the choice for them. However, we do have a responsibility to focus on their needs and whether the birth control method will be reliable for them. Women who have difficulty organizing their daily routines may not be good candidates for oral contraception, but with meaningful discussion they can reach such a conclusion themselves, and share this with their physician.

Until recently Canadian schools of social work did not offer courses in human sexuality and contraception. Even now only a small percentage of students takes this elective, and usually they are reasonably comfortable with the topic. Has the profession a responsibility toward the future clients of the remaining students?



Workers,\* like clients, are products of their culture with its values and norms, and of their personal life experiences. In-service training programs can increase awareness of one's feelings and attitudes and how these affect sensitivity to clients and to communication. If both clients and workers are hesitant, not much is accomplished. Do we not at least have the responsibility to introduce the topic and let our clients know we are comfortable discussing it?

Workers have many competing tasks and responsibilities, thus, frequently family planning counselling has been given on request only, if at all. Explicit agency encouragement is necessary to modify this practice. There needs to be a clear policy with administrative support and backing. Expectations of workers and supervisors need to be defined. Supervisors should be included in training sessions as they are in the position to encourage or discourage worker involvement in this area. New workers quickly learn what is "acceptable" practice (as distinguished from formal policy) from those around them. An assessment of learning needs will indicate the kind of in-service program required. Experience has shown if it is to be of value, a program must be of sufficient quality and quantity. The equivalent

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\* The term worker includes persons employed in public assistance programs and correctional and recreational services as well as child care workers.

of two days minimum is necessary to provide content, and make some impact on attitudes. Panels, films, role plays and small group discussions are ways of making information available and helping the integrative process.

Knowledge about birth control methods only is not sufficient. Contraception cannot be isolated from sexuality and a recognition and understanding of the complex feelings and behaviours involved. Workers' own sexual insecurity or problems interfere with their helping clients. Workers may lack information and be uncomfortable acknowledging this. They, too, may be caught up in some of the myths surrounding sex. Imparting knowledge does not encourage promiscuity. A comparison could be made with teaching children about traffic and the use of traffic lights. Fortunately now one hears of family planning defined as a medical service less frequently, and most social workers recognize the educational and social components. Those in medical and rehabilitative settings realize the value of team work, and the need to be alert to social problems that might interfere with effective use of family planning services. To fulfill this role, social work must be considered a valued part of the team with knowledge and expertise to contribute.

Some agencies question making contraceptives available to single women or adolescents. Others question young women wanting a tubal ligation, in spite of the fact that they and their

partners know how many children they can cope with physically, emotionally and financially. We all make value judgments but do we consider the change in values? What does constitute responsible sexual behaviour? How comfortable are workers counselling sexually active minors? Do they, too, wonder if sex education in schools encourages sexual activity?

Some of us may get caught up with concern about the rights of parents, ignoring the rights of children. Children do have the right to be born into a situation where their basic needs will be met. Most workers recognize the stresses on a pregnant mother with several young children; the relationship between new pregnancies and deserting fathers is also known, as is that between family size and the ability of low-income families to cope and raise happy, self-reliant children.

Social workers have unique knowledge and expertise regarding their clients' feelings, attitudes and behaviour in social relationships. For example, what are the immediate pressing social problems that could interfere with contraceptive use? How might these be modified or alleviated? Studies have shown that the middle class tends to blame the user for contraceptive failure, while the lower class tends to blame the method. How might we use this information more productively? It is necessary to acknowledge and accept clients' religious beliefs and views, but it is equally important not to let these mask the other concerns

that may be interfering with contraceptive use. Do complaints about a method have only a physical basis or are they a reflection of feelings of guilt, marital strain or some unrelated crisis? Obviously a medical referral may not be sufficient. The value of anticipatory counselling about side effects, adverse publicity about the chosen method, etc., should be considered. Group discussion could be more helpful to some persons than individual counselling. The relevance of family planning for many kinds of parent groups should be considered. Some men may be uncomfortable speaking to a female worker about sexual matters, so counselling by a man should be possible.

It is important to understand the cultural differences and the meaning of motherhood for many women. For some their only achievement is producing children, although they may be unable to care adequately for them. Sexual relationships are often their only meaningful emotional experiences. It is a challenge to social work to help them find alternative satisfaction, to intervene in a destructive (for mother and children) pattern. Ways of increasing feelings of personal worth and satisfaction with self must be found. It is a slow, discouraging process. For deprived women, contraception must be related in concrete and tangible ways which offer realistic hope for a better life. Are there other gratifications to compensate a woman for those received while pregnant?

Life skills programs such as those offered by the YWCA can be helpful, but much time and energy is needed on the part of the leaders to motivate the mothers to attend regularly. For some, it may be necessary to take them to meetings. Many isolated women are fearful of groups, and need help in acquiring basic social skills. Activity groups, gym or swimming classes, all increase feelings of self-worth. Needless to say child care facilities need to be available. Contraceptive discussions can informally take place and be much more effective in a relaxed atmosphere. It is important for a worker in any setting to take advantage of the opportunities offered to introduce the topic. It is then possible to continue the discussion on future occasions. These women need to hear that they do have a choice--that one does have control over one's behaviour. If a person is knowledgeable and can recognize the risk situations, a satisfactory decision can be made.

Many women experience ambivalent attitudes toward pregnancy, while not wanting parenthood. They need help in acknowledging and coping with these contradictory desires and needs. Some women are as preoccupied with pregnancy and having children as some men are with their potency. Such strong feelings and conflicts must be taken into account when discussing contraception and helping maintain motivation. Young women who deny to their friends the fact that they are involved sexually may

have doubts and be unwilling to accept their own behaviour, or make a definite decision and take responsibility. Such women risk an unwanted pregnancy. Other factors which may indicate a health risk for the woman if she becomes pregnant, and/or for her infant, are age (those under 17 or over 35 years), parity (those with five or more children), the interval between pregnancies (less than 24 months since the last termination) and medical history. Income and marital status are additional factors which may need to be taken into account. High-risk mothers need to be urged to avoid or postpone pregnancy, and should receive close follow-up. Social workers should consider how they can work co-operatively with medical personnel to identify and convince these women of the need for birth control. Time will be needed for them to accept and weigh the risk to themselves or future children.

Workers also need to be alert to the need for genetic counselling and infertility counselling, and knowledgeable about community resources where these are available. Workers in child welfare, youth and family agencies should be prepared to offer abortion counselling or to make a sensitive referral if for personal reasons they cannot do it themselves. Abortion counselling includes giving contraceptive information as well as helping people recognize and come to terms with their sexuality. Social work is becoming involved with averting unwanted births, as well as unwanted pregnancies. We need more expertise.

While as outlined, the social work role in the area of family planning might seem like a full-time job, it need not be if it is integrated into our daily tasks. Abortion counselling is one of the options a person should have in making a decision about an unwanted pregnancy; it should be included along with discussions about whether the child would be kept or given up for adoption. Helping parents limit family size may mean the difference between an adequately functioning family or one in crisis. Prevention takes planning and coordination, but does it take more time than "helping to pick up the pieces"? Social workers traditionally have functioned on a "cure" approach rather than a preventive one, and we deserve the criticism we receive for this. We need to be more aggressive, to reach out and challenge. We have as much responsibility to discuss family limiting with an already burdened mother as has her physician or the public health nurse. We may know more about her situation and, if so, be in a better position to understand her possible reluctance and anxiety.

Public assistance workers may hesitate to initiate discussion, fearing they might be considered coercive, but it is essential that they determine whether the women they counsel have adequate knowledge about birth control methods and services, including those made available by their department.

Providing contraception for minors presents emotional,

social and legal problems for the helping professions. However, for sexually active adolescents protection from pregnancy is the most immediate concern. For many there is considerable peer pressure to have intercourse, and for some to become pregnant.

In all social strata, diminished parental guidance, the impaired communication between generations, general mobility, the decreasing support of extended family, increased unsupervised time spent outside the home with resulting lack of close family life, and greater importance of peer relationships may all lead to more loneliness and anxiety and more opportunity and need for sexual relationships.

The young female in her teens and twenties must find a subtle balance between her physical development, her emotional maturation, her feelings toward her parents, her relations with peers, her intellectual development, and her identity as a woman. Her family has been the training ground where she has developed feelings about herself, her qualities, and her abilities and which has prepared her for her adjustment to society...2

Some adolescents "hit out" at a parent by becoming pregnant; many others are given ambivalent messages by their parents regarding their behaviour.

Persons working with certain adolescents are concerned about the high incidence of pregnancy and the apparent encouragement from a mother for her daughter to have a child, almost as a continuation of her family. Involvement with these adolescents alone is not sufficient. It is also necessary to help their mothers find meaningful roles other than raising babies.

A comprehensive sex education program emphasizing



responsible parenthood is crucial to an effective family planning program. Informal discussions including dating, emotions and children's needs can put contraception in an appropriate context. Drop-in centres and other meeting places could produce a more spontaneous questioning than a classroom setting. Parents of younger adolescents or pre-teens need to be involved in planning programs. There is less chance of their opposition when they understand the rationale and content. Planned Parenthood organizations have volunteers who could help lead discussion. These adults must be comfortable with young people and able to handle questions as well as to anticipate concerns and discuss them. Many agencies have regular group meetings for adolescent clients. Many young people desperately need role models who can demonstrate another way of life--one attainable for them. Young women who have little sense of their own worth are unable to assert themselves with their boyfriends. They need much help in sorting out their feelings and behaviour, including their attitudes towards contraception. In their case, peer pressure from the agency group might be able to exert a positive influence. Both male and female leaders are essential to such groups. School social workers can also play a significant role in interpreting, coordinating and initiating programs with other school personnel. Collaboration can be stimulating and satisfactory for all participants. Child welfare agencies have a responsibility to provide

information and, if needed, contraceptives to their wards. Because of their experiences in life, many of these adolescents are liable to become pregnant and therefore need to be protected from pregnancy until they are ready for the responsibilities of parenthood. It is not sufficient to give a young woman a prescription for a birth control pill. She also needs to think about future relationships and whether they are to be sexual. If she is challenged to do this, it can help her look at her behaviour and make some responsible decisions. She may interpret such a challenge to mean that the worker really cares about what happens to her, whereas a more permissive attitude might not be helpful.

Adolescents separated from their families and living in group situations particularly need help to make their own decisions and not be swayed by group pressure to become involved sexually. Staff should be sensitive to such situations and skilful in handling them. It is essential to avoid giving double messages. Child care personnel may need training sessions in which to discuss their own concerns and learn to work co-operatively recognizing each other's differences.

There is an increasing number of young adolescents who, although they are not sexually active, are knowledgeable because workers (including those in recreational facilities and drop-in centres) have taken time to really talk with them about

themselves and their sexuality. They are now in a position to make a more responsible decision about future behaviour. However, there are also workers who are uncertain about their role or the agency's policy, who miss opportunities to help young people. Another problem is that of workers who have such definite opinions about contraception or abortion that they inhibit discussion and the making of a responsible individual choice. This can be particularly serious where a worker (such as a child care worker) has considerable influence.

Pediatric or adolescent clinic personnel can serve as casefinders for teens at risk: those with an illness such as diabetes that could be complicated by adolescent pregnancy. Workers with the retarded must offer assistance to both the young people and their parents. The latter have many concerns about their children's sexuality and their vulnerability.

Any agency working with families certainly must consider some discussion of birth control as part of their counselling service, whether such discussion is requested or not. It is an essential part of marital counselling. If the worker is comfortable with the topic and sensitive to the couple's needs, there should be little difficulty. Diagrams, models, and samples are helpful in clarifying terminology. Several sessions may be necessary, depending on the knowledge and comfort of the client. Industrial social workers can informally discuss family planning

with groups of staff or during counselling sessions.

Some situations are more crucial than others because of the stresses already involved. Persons in such situations include psychiatric patients either on leave or ready for discharge, patients in rehabilitative programs, persons on parole or probation, alcoholics and those with drug problems. Giving them contraceptive information is not sufficient. The worker must be actively involved, assessing the degree to which an individual is capable of assuming responsibility. Oral contraceptives may not be as appropriate as an intrauterine device. It is also necessary to consider needs of patients and the degree to which they are "at risk" in the community or institution. Certainly the added stress and complication of pregnancy should be avoided as they begin to integrate themselves into their families and community, and forthright discussion is necessary. Families and relatives need to be aware of this and included in plans.

All workers have contact with individuals and families who can use family planning services. Miriam Mednick sums it up: "If we do our job in emphasizing the 'social' in social work, we will fulfil our responsibility in family planning."<sup>3</sup>

#### FOOTNOTES

<sup>1</sup>Virginia Insley, "Patterns of Program Development in Family Planning," in Family Planning: The Role of Social Work, ed. Florence Hazelkorn (Garden City, N.Y. Adelphi University School of Social Work, 1968), p. 90.

<sup>2</sup>Philip M. Sarrel, and Ruth W. Litz, "Psychological Factors: The Unwed," in Manual of Family Planning and Contraceptive Practice, ed. Mary Steichen Calderone (Baltimore: The Williams and Wilkins Company, 1970), p. 251.

<sup>3</sup>Miriam F. Mednick, "The Social Worker's Responsibility in Family Planning," in The Social Worker and Family Planning, ed. Joanne F. Gorman (U.S. Department of Health, Education and Welfare, 1970), p. 56.

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PSYCHOSOCIAL ASPECTS OF FAMILY PLANNING:  
THEIR SIGNIFICANCE AND PLACE WITHIN THE COUNSELLING PROCESS

Jules-H. Gourgues, M.S.W., M.Sc.F.S.

I know very well that the doctors have positively advised me against having a baby, that they have pointed out that it would practically be a suicidal move for me . . . I know all that . . . but, you know, I can't help it, I want a child and I'm not at all sure that I won't manage to forget my pill at some point . . . I know that, too, unfortunately.

What person with experience in family planning has not been shocked to hear just such a thing at one time or another in their office? Could we find a better example of the place a child can hold in someone's life?

No, we must stop right there. Are we not right in thinking that most readers have understood only that the birth of a child can represent a risk to the life of the mother -- her physical life? And this is not at all what should be seen. The example is clear and says, in other words, "it may be that to this woman the birth of a child represents, on the personality level, such a great desire and such a psychological need that it can outweigh taking the risk of disregarding a physical counter-indication, even one so absolute as to be a threat to life." The reasoning is very simple: if first we agree that the need for a child is mainly a psychological one and, second, that family planning represents a person's ability to exercise self-control and make decisions with regard to the need and desire for a child,

we cannot then deny that it is primarily a psychological function.

What old hand in family planning has not also listened attentively to something like the following:

According to what the doctors have told me and keep telling me -- that I must absolutely not have a baby -- I know that getting pregnant would mean running the risk of dying. But I am so anxious to give him a child that I am not certain I am strong enough to follow their orders . . . .

The same reasoning holds here: the wish to have a child to satisfy the expressed or unexpressed desire of the husband or other family members means that the need for a child is equally, and very strongly, social in nature. This means that the action of planning to have a child is characterized by a high social component. Let us consider the important part of motivation for family planning that is on the "social" side: pressure from surroundings, feelings of competition, a desire to pass on the family name, pressures from the future grandparents, life style and ecological conditions.

These elements alone, despite their limitations, free us from a more detailed demonstration (already made elsewhere)<sup>1</sup> to prove that family planning is a function which far exceeds merely physical and medical aspects, and that it is at best a psychosocial function with a physical manifestation; in short, that it cannot be grasped without understanding the personalities of those involved in the planning nor by disregarding their social environment.



### The Problem

Despite their evident significance, what importance is usually given to psychological and social aspects within the professional area of family planning? Let us consider the state of research in the field. What is left that has psychosocial content once all the medical research has been taken away, along with efforts to help developing countries, concern about overpopulation, long discussions relating to ideology and morals? What does this research teach us of the profound significance of the function of family planning on the personality level? At least part of the answer can be found if one realizes that, in all the abundant literature in the field, there is only one book that could really be presented as a treatise on the psychology of family planning: Psychology of Birth Planning by E.W. Pohlman.<sup>2</sup> Even then, people familiar with this book will admit that it really represents a study of all the non-medical aspects in this area rather than simply a study of the psychology of family planning.

To summarize, at a time when medically there is talk of the possibility in the not-so-distant future of such things as the "once-a-year pill," reversible sterilization and "the pill for men," we are still taking the first faltering steps on the psychological side of family planning.

### Going Beyond the Principle

It is not generally in accepting the principle itself that the problem arises (the amount of literature on the subject is, in

fact, becoming more and more respectable); it arises rather because of the numerous implications and consequences there are in creating programs and organizing services for family planning counselling. If there is agreement on the theoretical importance of the psychosocial elements family planning, then these same elements should be evident in any operation within that field. In other words, if the client's family planning needs cannot be handled without reference to psychosocial components (varying in extent but always present), it is readily apparent that services intended to meet client needs must also respond to psychosocial needs. In short, it is proposed that any family planning service should include appropriate services of a psychosocial nature.

#### A Challenge for Social Services

At this level a psychosocial orientation makes all the difference; it becomes a real commitment and goes beyond theory, involving social workers directly in every-day situations. It is not enough for the psychosocial counsellor to gain the acceptance of health professionals for his or her front-line role in delivering these services; he must also prove himself through the suitability of his concrete professional actions during this process.

A complete description of the psychosocial aspects of family planning (especially a detailed expression in terms of intervention) has never been the subject of a completed work; this is a big job and a real challenge for professionals involved in psychosocial assistance and for the social services in particular. When

we consider in detail the numerous important tasks that this work involves, we even get the impression that it might, when completed, mean a considerable revolution in the professional area of family planning.<sup>3</sup>

#### Definite and Important Tasks

Keeping in mind the preoccupation of clinical services, and even trying just to present a summary in this preliminary work, we find ourselves faced with the following minimum list of tasks that must be undertaken if we want to meet our objective:

1. Description of the role and functions of the social worker in family planning work;
2. Definition of the place held by psychosocial counselling within the clinical process;
3. Developing a model for the psychosocial section of the clinical file;
4. Creation of teaching and working tools (measurement scales, attitude and motivation tests, audiovisual tools) suited to these tasks.

More specialized questions (training, research) will be raised once there has been preliminary clarification in this area; the priority aim here is not to consider the entire job of the psychosocial counsellor, but instead to attempt to supply elements that might allow us to go beyond the principle we have set out. In summary, the question is to find out what place psychological counselling and related services must have within a total network of clinical services and how this should be expressed from day to day.

### Creating a Frame of Reference

In formulating a frame of reference we are faced not only with the magnitude of the task but also the necessity of starting from scratch. This is, moreover, probably the best explanation of why, even though the psychosocial view of family planning has won fairly general acceptance, researchers are hesitant to define it right down to the details of the clinical intervention. In such circumstances it would be pointless to list all the psychological and social elements that enter into defining the need for family planning. It would be better to provide ourselves with an analytical instrument, a framework, to take stock of various approaches that could be used as guides to identify these elements while making the work more systematic and better structured.

### An Attempt to Define Some Approaches

What, then, can these various approaches be? To begin with, they must of necessity related to both the psychological and social elements involved in family planning counselling. As soon as they are placed within the confines of the psychological and social, we are able to identify two important factors: the personality of the client or couple, and their social environment. These factors form a large part of the psychosocial needs for family planning counselling.

Moreover, it is known that the duties of any specialist in family planning counselling are defined differently according

to the various stages reached in the counselling. It is therefore probable that by identifying the various stages of psychosocial counselling related to family planning, significant light might be shed on the counsellor's duties. A third approach would then be involved -- an attempt to perceive the main phases, no longer of the general process of family planning but rather, at another level entirely, the process of family planning counselling. In short, it is no longer a question of considering the development of the need for family planning on the level of the total personality but rather to analyze what stages of counselling the client couple must pass through in order to obtain answers to that need: to examine in depth the path they must follow in their approach to psychosocial counselling. Since these elements are essentially different, it must be expected that this analysis will constitute a third approach to the question of the psychosocial counsellor's role.

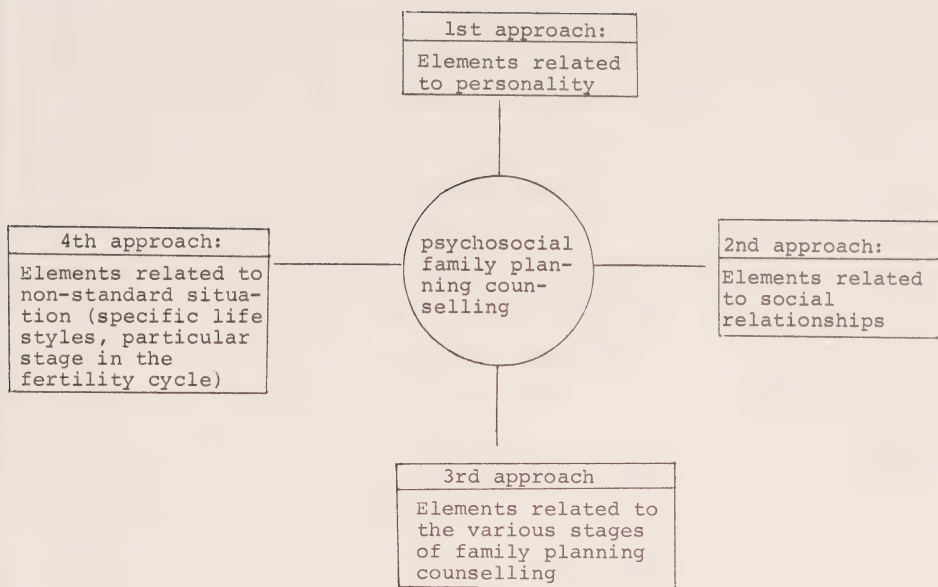
Finally, we are aware that the three approaches identified until now refer to what might be called "the standard situation" for counselling. In any sphere of counselling there are exceptional situations brought about by such factors as the client's needs, or his case history may present certain characteristics that create "non-standard" situations".

We think first of exceptional conditions related to specific life-styles (single-parent families, prolonged absence of spouse) or to some "pathology" on the personality level or

the level of social relations (mental deficiency, poor social adaptation).

However, counselling for family planning, unlike many other types of counselling, does not in itself constitute a response to a given pathology or other problem. In other words, it is not solely or mainly related to "problem-solving". Are there, therefore, specific counselling situations which are neither "pathological" nor "problematic"? If we exclude the personality factors per se, and the elements related to social relationships (both of which have been covered already), we will find at this level certain situations occurring because the client couple is going through a stage specific to their fertility cycle. The specific stages in the fertility cycle must then also be considered within the fourth approach via non-standard counselling situations.

Thus, four precise approaches may be defined in order to attack the question of psychosocial counselling in the field of family planning, and to identify the main elements:



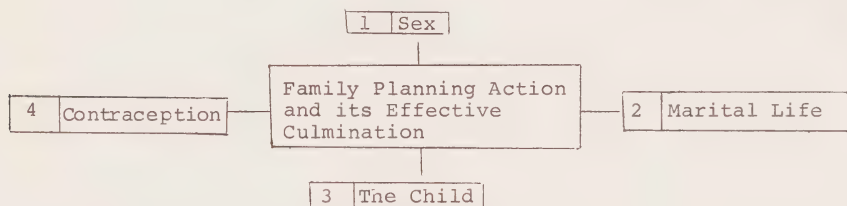
Let us then see how each of these different approaches sheds light on the content of psychosocial counselling for family planning.

1. First approach: Elements Related to Personality

This approach consists of asking ourselves how a person or a couple develops a need for family planning and through what process his or her personality must go before adopting effective behaviour. In other words, what is the background for effective family planning? Effective family planning behaviour must then be considered as the end result of a precise and specific action on the personality level and an attempt must be made to identify

the various phases leading to this culmination. The phases should be identified from the very earliest to the most recent (this means that a certain amount of chronology is present).

A model has already been created to answer this question,<sup>4</sup> so it will simply be reproduced here with adaptations to this work. The point of departure for the model is a repetition of the statement that effective family planning behaviour may be seen as the desired culmination of actions that revolve around four specifics: sex, marital life, the child, and contraception. The following arrangement takes this order of progression into account:



a. The Sexual Aspect

The sexual aspect is therefore presented as the first universe from which effective contraceptive behaviour is formed and developed. The sexual relationship occasions the need for family planning and justifies it in a practical manner; also, sexual attitudes -- formed from earliest childhood -- represent one of the most deep-seated sources from which this behaviour emerges. From there on it is only necessary to identify the precise steps and sub-steps of the family planning behaviour that



are located within this universe.

Based on the classic triangle of "attitudes -- knowledge -- behaviour," the model defines the three corresponding moments in the sexual universe: the formation of sexual attitudes, the acquisition of sexual knowledge and the actualization of sexual behaviour.

However, after empirical analysis, the model considers that questions of motivation and decision-making related to sexual life are highly important. It proposes that these two points be specifically identified and added to the third stage: sexual behaviour<sup>5</sup>. Now we are left with the following content related to the sexual universe:

1. The formation of sexual attitudes;
2. The acquisition of sexual knowledge;
3. The development of sexual motivation, decision-making with regard to sexual life and actualization of sexual behaviour.

Defined in this way, the sexual process for family planning action seems particularly complete. Its elements also seem to lend themselves particularly well to clinical action; attitudes and knowledge can be easily measured in an interview either with or without the use of existing numerous tests and measurement scales; motivation may be equally easily ascertained in an interview, both in qualitative and quantitative terms. Decision-making and analysis of sexual behaviour constitute a priority of the interview that can also be measured if approached

in terms of "level of sexual satisfaction".<sup>6</sup>

It would appear that this first universe contains most of the sexual elements that must be considered in psycho-social counselling for family planning.

b. Marital Life

Here perhaps marital life should be put under the heading of social relations, but it may also be useful to consider the client couple as an entity to itself, beyond the mere "female client."

Just as it might have been necessary to distinctly differentiate between sexual counselling dealing with sexual dysfunction and the portion of planning that deals with sexuality, we must distinguish here between marriage counselling "at large" and counselling for family planning within a marriage. The latter, in fact, should never go beyond its aim and serve as a means of access to or a pretext for "solving" marital problems that are much broader; it can only -- in a case of a total marriage problem -- serve as the occasion for referring a couple to a marriage counsellor.

In these conditions, and keeping in mind that "sexuality" and "the child" are treated as separate poles, the question here becomes that of finding out what are the minimal elements within a marriage that have a stable effect on contraceptive behaviour. If, in addition to this model, we examine factors identified in research by Renée Cloutier-Cournoyer,<sup>7</sup> we have the impression that the following general themes are sufficient to ensure that

elements within the marriage are properly considered in a family planning interview:

1. The level of satisfaction within the marriage;
2. The level of sharing and agreement with regard to the spouses' roles in family planning action;
3. The value of communication between the partners.

Here again we are faced with themes that over the years have brought about the creation of numerous measurement instruments -- in particular measurements of marital satisfaction. It seems relatively easy to approach these themes during psychosocial counselling related to family planning.

#### c. The Child

This third division has priority in relation to family planning counselling. In fact, like the universe of sexuality but to an even greater extent, the universe of the child is directly and specifically affected by counselling. It even represents the main focus of family planning action and it must also be included as one of psychosocial elements discussed during counselling. However, it is all too often set aside or partially ignored both by the client couple and by the family planning counsellor. It is not in the least impossible for both of the clients and counsellor to be so preoccupied by the technical side of family planning that they forget the main point of it all.

However, it is only elementary logic that any couple desiring to plan its fertility must first decide about a child.

This stage of communication within a marriage, where the couple sets out its aspirations and exact positions regarding the birth of a child, constitutes the key to clearly accepted and totally conscious family planning -- planning that goes beyond the purely negative approach of simply "avoiding" the birth of a child. This is why the model chosen, once it has considered the sexual and marital universe, identifies within the family planning process a third sphere essentially concerned with the child.<sup>8</sup>

It can be considered that motivation to have a child is preceded and dictated by all the attitudes that the couple has regarding a child. These attitudes represent all the values that the couple assigns to a child and which make the couple more-or-less in favour of having a child, more or less prepared to make room for it in their lives. These attitudes are behind one's motivation either to have a child or children or not to have one. Once these attitudes are clarified they bring about a couple's decision regarding a child. This leads them to adopt the appropriate behaviour. As far as the child is concerned, then, the related elements in psychosocial counselling are the following:

1. Attitudes of the client towards a child;
2. Motivation to have a child;
3. Position in relation to a child.

Even though the instruments of measurement here are much less well developed,<sup>9</sup> it seems obvious that these themes can easily be raised during a psychosocial interview; this fact should result in the production of the necessary instruments lacking at present.

d. The Contraceptive Universe

From the moment when a couple's decision regarding a child creates a need for family planning, we must consider that the last elements of the family planning process must, on the personality level, be related to the contraceptive universe.

But before getting to contraceptive behaviour, we come to the question of the client's attitudes and values in relation to family planning and its method. It is one thing to decide to have a child in two years and quite another to rely on family planning to attain this objective. The heavy moral connotation that is still related to this forces us to consider this question of contraceptive attitudes separately.

Just as attitudes toward a child lead to motivation to have a child, so do contraceptive attitudes lead to contraceptive motivation -- that is, motivation on the part of the client couple to actualize family planning behaviour and conform to the rules of use for that particular birth control method. This motivation leads the client or clients to make a decision in favor of contraception or to use one or another

method and thus eventually to achieve contraceptive behaviour or varying effectiveness.

Thus, the elements to be considered under the heading of contraceptive action are:

1. Contraceptive attitudes;
2. Contraceptive motivation;
3. Contraceptive decision and contraceptive behaviour.

This has brought us to the end of an examination of the elements within family planning action seen from the point of view of the personality. Now we must follow the same process with the second approach, that of social relationships.

## 2. Second Approach: Elements Related to Social Relationships

Since an appropriate model is not available for this approach, we will propose a hypothetical schema based on various types of social relationships most involved with family planning. In other words, our approach here will be far more illustrative than exhaustive.

Since marital relationships have been discussed, the first type of relationships to be covered here concerns family relationships between parent and child and between siblings.

### a. Family Relationships

It seems essential to consider the level of satisfaction each family member gets from his relationships with the others. For example, it is important for the psychosocial counsellor to evaluate the image the parents have of each of their children,

of them and to verify educational values in terms of equal consideration given each child, in terms of dependence and independence, in terms of how greatly the child was wanted in each instance and in terms of the satisfaction of each parent in relation to the sex and development of each child -- in short, in terms of the quality and weaknesses of the teaching approach adopted by the parents in training their children and in terms of day-to-day relationships between the children.

Once this preliminary evaluation is made, light can be thrown on family planning action if we consider each of these elements, introducing first the hypothesis of the birth of another child and then the hypothesis that the parents are either totally against such an event or desirous of delaying it. A portrait of family relationships must be established and we must then try to see how it would be altered if the clients were confronted by these three hypothetical variables of future fertility. Such an analysis, based on fixed and pertinent criteria, should allow the psychosocial counsellor to make a clear distinction between these three possibilities related to the birth of another child. It is, however, quite obvious that such a procedure applies only to the couple who already have one or more children; it must be restricted to marital interaction in the case of childless couples.

b. Professional Relationships

A second aspect of the analysis of social relationships may relate

to the sphere of professional relationships. The level of satisfaction that the partner finds in his or her work and the satisfaction that this brings to the other partner seems essential to the couple's choice of whether or not to have a child. Here again it will be a question of identifying set criteria for satisfaction of expectations at this level and to introduce in the same way (still at the hypothetical level) the three choices the couple may take regarding a first or additional child.

c. Recreation and Social Life

All client couples have their free-time activities and specific relationships with friends and family. These elements condition their attitudes toward a child. To give an every-day example, which of us does not know a couple so involved in a sport that they cannot consider having a child without immediately thinking about how the child's presence would affect their participation in that sport? Who does not know of couples whose friends are all having babies and who find it hard to go against that trend without feeling "odd-man out?" Evaluating the restrictions related to these two spheres of social relationships seems equally vital within the field of psychosocial counselling for family planning.

d. Relationships with Relatives

In the family planning field, much is made of the desire to become a parent; but perhaps not enough is made of the desire to be a grandparent. Everyone, though, is well aware of the very real pressure put on a new couple by their parents who are anxious to



have a grandchild and relive joys they have not felt for many years and which make them feel so much younger. This pressure, which may either result from the older couple's actual desire to become grandparents or from their concern to conform socially, is real and should be considered by anyone working with the psychosocial side of family planning.

e. Material Conditions and Housing Conditions

It is a well-known fact that motivations related to income are by far the most frequent type of motivation connected with family planning. A precise statement of this question as it relates to the general material conditions in which a couple must live would therefore appear to be of prime importance. Analyses of the availability of housing, the possibilities of the present accommodations, restrictions related to one of the partners' stopping work, prospects related to salary increases and savings, indeed every detail of the family budget, all represent essentials in a couple's evaluation of whether to have a child.

Life Style and Social Environment

It is no longer rare for a couple to feel reluctant to have a child, given the facts that modern life is becoming less and less attractive ecologically while at the same time becoming increasingly hectic, competitive and stressful. Such changes have resulted in more than one case of rejection of, or outward disengagement from society. The psychosocial counsellor in family planning must know how to consider these new elements -- elements that are

growing in consequence and pressure with every day.

In summary, the various elements on the social level that influence contraceptive behaviour are:

1. Family relationships;
2. Professional relationships;
3. Recreation and social life;
4. Relatives;
5. Material conditions and housing conditions;
6. Life style and social environment;

### 3. Third Approach: The Process of Family Planning Counselling

We have just spoken of the place of family planning in the area of personality. Now we will analyse another more limited action, that of psychosocial counselling for family planning, or the process of referring to psychosocial counselling services. To have a proper understanding of the subject, we should identify the various steps between the appearance of the immediate need for family planning and the regular use of a family planning method. Here we can refer to an existing model<sup>10</sup> showing four main themes within psychosocial family planning counselling: motivation, individualized information, choice of method and perseverance in using that method.

This model appears fairly complete and therefore will be used, with adaptations, for our third approach. These various themes could be considered as precise steps in the process of psychosocial family planning counselling. Thus, all that needs

to be added to the four stages already identified would be a fifth initial phase related to making the client aware of his need for family planning. The five stages in the counselling process then are:

1. Awareness;
2. Motivation;
3. Individualized information;
4. Choice of method;
5. Perseverance in using a method;

a. Phase one: Awareness

The preparatory stage for counselling action generally corresponds to an essentially private awareness of the need for family planning, based on a personal experience that encourages family planning (e.g., the recent birth of a child, a parent's return to work) or on the availability of general information about family planning. Reaching this first step will present the following alternative: either the couple will decide that it does want to have a child right away, that it will not or cannot use a contraceptive method or will use a method that does not require clinical consultation, or else the couple will decide that they do indeed need family planning and will use a method requiring consultation. The latter alternative will be considered here, since the former does not lead to consultation and therefore does not enter the framework of this approach.

From the time the client decides to consult, he is led to

make contact sooner or later with a centre providing birth control services so that directly after counselling the client can use an effective and acceptable method of planning. From his very first contact he will be exposed to the usual introductory activities, and possibly to a group session; these activities may be seen as also being part of the phase of creating awareness.

b. Phase Two: Motivation

Before going for counselling, the client has, of necessity discussed his or her need in private and gone into it at least in a preliminary way. When the family planning centre receives the client it is probable that the client has not yet completely decided on the need for family planning; the client will probably need the assistance of a psychosocial counsellor to complete that phase. Then the motivation phase begins.

The client's decision to use a family planning centre represents a level of involvement far below that of taking a final decision to immediately begin family planning. i.e., starting off on the process of consultation and using a birth control method rigorously. This is why an early form of psychosocial intervention might consist of exploring with the client his or her actual motivation to become a "family planner" and to assume the consequences. At this level, moreover, another a phase of analysis appears.

e. Phase three: Individualized Information

From the time the client decides whether or not to have a child,

(a decision reflected in a desire for control over his or her own fertility), the provision of information becomes essential. The client couple has not yet received all the necessary contraceptive information and has not necessarily chosen the method that they wish to use; they need information in greater detail. However, this need is not for the same type of information received in the preliminary awareness phase: now it is no longer a question of general information on all methods but of a personalized and utilitarian direction. The information must be closely related to the highly personal situation of the client couple and centred on the family planning method or methods that suit them. In other words, general information must be adjusted to the client's highly personalized needs. The information transmitted during this third phase is essentially aimed at enabling a specific person to make the most efficient use of a particular family planning method.

d. Phase Four: Choice of Method

Once the client couple has decided to control its own fertility by family planning and is sufficiently motivated to do so effectively, they need help to determine the birth control method best suited to their personal situation. This fourth step consists in general, of analysing in depth with the client couple the various methods that seem acceptable to them and helping them choose the particular method they think will be used most effectively.

The step of choosing a method, like all the other steps

in the counselling process, may be completed when the convenience rates for the various methods under consideration have been analysed and measured in relation to the psychological and social elements described above, and the clients made aware of the method that has the highest success rate. Phase four of course ends with the definitive choice of method to be used.

e. Phase Five: Perseverance in the Use of a Method

Obviously a couple's rate of success and continuance with a method has much more to do with the characteristics of the psychosocial situation than with the simple act of following to the letter the technical and medical instructions related to its use. We have already shown how the very concrete psychosocial conditions of life that accompany this use can make highly significant changes in the rate of theoretical or "laboratory" effectiveness of the various methods.<sup>11</sup> It is therefore very appropriate to discuss this last phase of contraceptive action under the theme of perseverance in usage. Indeed, a significant portion of psychosocial counselling should be given over to this question, first of all at the pre-utilization level by an analysis of a client's chances of perseverance and continuity in using the method chosen. This concern also comes into play at the follow-up stage in a client's use of a method so that a counsellor can see if the evaluation or "forecast" made in the pre-use period has proven correct and if changes in the client's psychosocial situation have altered this perseverance.

This, then, covers all the various stages in the process of psychosocial counselling in relation to family planning. We now have a better understanding of the way in which this third approach (especially in comparison with the others) in its own way sheds light on the identification, understanding and especially the systematic structuring of the psychosocial elements present in family planning counselling.

#### 4. Fourth Approach: Non-standard Situations

In discussing the fourth approach, the author does not wish to give the impression that the psychosocial counsellor intervenes in the role of therapist in the type of counselling dealt with here. Family Planning counselling is generally seen strictly in terms of growth, prevention, assistance or creation of awareness, rather than as a "solution" to problems characterized by and requiring diagnosis.

This does not, however, alter the fact that exceptional situations arise for a number of reasons (e.g., living conditions, state of health); in such situations the need is not presented within the usual co-ordinates. Although we cannot speak of such situations in pathological or nosographic terms, nonetheless their specific character can considerably condition the approach adopted for psychosocial counselling. It is therefore important to be aware of these situations and able to recognize them, especially the specific psychosocial elements they involve which are not necessarily needs normally presented for psychological

counselling. This is why we speak here of "non-standard situations" and not of "pathological" or "abnormal" ones. We will attempt to identify these various situations, since we believe that only through their identification can we become more aware of certain psychosocial elements in family planning counselling -- elements not covered previously in this article. As a point of departure, we will use a study done by Françoise B. Lamontagne and Jules-H. Gourgues, to identify "common and specific needs" in the area of family planning.<sup>12</sup>

a. Situations Characterized by an Unstable Sex Life

A significant number of persons using a family planning centre, live in conditions unfavourable to carrying on a sex life that is as stable as the average. These people include heads of single-parent families, teen-agers, those in situations where one partner is absent, couples who live together from time to time, partners, with different work times, and so forth. It appears that an unstable sex life can directly influence a client's motivation for family planning, his or her choice of method and perseverance in using it. Who has not seen a client taking the pill without any qualms during an intense love affair, only to question her choice after it broke up, begin to "forget" a few pills and then get pregnant from a passing relationship. Possibly this group is most vulnerable to accidental pregnancies because a dramatic breakup in a love affair may result in strong feelings of abandonment, leading almost automatically to the client "giving up on everything," including



contraception. This attitude may severely complicate her situation if it results in an unwanted pregnancy. It is clear that the psychosocial counsellor should anticipate these situations and intervene.

b. Situations in Which There is an Absolute Contra-Indication to Pregnancy

Such situations are not just restricted to physical contra-indications to pregnancy since psychological contra-indications can be just as real. Of course, one first thinks of a strict medical contra-indication such as in the case of a woman who has had several Caesarian deliveries or a woman whose state of health would not withstand a pregnancy. However, there is also the case of a couple in an advanced state of separation who see the birth of a child as the miracle solution -- the life-buoy to a union that is drifting apart -- even after all other solutions have been tried and have failed. The influence of such a solution on client's shows in the choice of contraception and perseverance in its use; there must, with the help of the psychosocial counsellor's enlightened intervention, be as totally effective use as the contraindication is total.

c. Situations Involving an Irregular Reproductive Cycle

The classic example of this is the airline stewardess whose menstrual cycle can be affected by flying and whose problems in this area have become legendary and are part of the job. More generally these situations include all disorders of the menstrual

cycle, postpartum or postabortion irregularities, the frequent instabilities of puberty, and cases where women are from time to time are subjected to emotional shocks, overwork, periods of intense nervous tension and so on.

Of course effective help at this time is mainly medical, but it must be expected that a parallel psychological state will develop. Certainly, a counsellor must give a client precise guidance about both choice of method and perseverance in it.

d. Situations of Sexual Life "Outside of the Norm"

The situations in this category have already been discussed under the previous headings, but here we are looking at them from a different angle. The accent here is placed on the "deviant" character of the client's sexual life, with its risk of carrying with it to those involved a particularly acute feeling of guilt, a strong impression of being "beyond the norm" and consequently a need for psychological support in the face of social pressure. A psychosocial counsellor's intervention at the motivation level as well as the counsellor's strong, clear guidance to clients regarding a choice of method and perseverance in its use, can ensure that the effectiveness of contraception cannot be reversed by guilt feelings.

e. Sub-standard Living Conditions

We have already mentioned<sup>13</sup> the impression of senselessness -- "professional heresy" that we get from people speaking of family

planning with regard to the disadvantaged, since it is not naturally a part of the world of such people to plan anything in their lives. We cannot insist too much on the necessity for psychosocial counsellors to be very wary of the traps for family planning that hide behind this mentality of "living for today" and aware also of the great necessity not to let conditions of great ignorance or unequal access to material and psychological resources create unjust family situations because of unwanted children.

f. Situations Involving Marital Difficulties

We have already spoken of the child on whose shoulders rests the continuance or break-up of a marriage. There are the most obvious cases where the couple's position regarding a child must be given all the attention and assistance possible from the psychosocial counsellor, and many others, where the future of the marriage is so precarious that one cannot clearly see what direction should be taken with contraception. Obviously such uncertain conditions should prompt counsellors to refer these clients to a specialized marriage counsellor, although this does not eliminate the urgency for family planning intervention even if it is only during marriage counselling.

In the case of less deteriorated situations there is still the possibility that the two partners will not agree to participate; this means that the psychosocial counsellor must increase their vigilance with regard to the consequences any family

planning decisions may have on the marriage. Finally, the significance of a child's birth in such circumstances and the often severe consequences for the child should lead the counsellor to approach the various stages of counselling in greater detail and to propose a follow-up.

g. Extramarital Sexual Situations

Considering the statistics on the subject, we have the distinct impression that workers in family planning too often take it for granted that the sexuality of married couples is limited only to the relationship within that marriage, or in other words only within the "legitimate union." Such ignorance of the true situation may have harmful consequences on the offspring of certain parents. Just think of the severe damage both for the child and for the parents in a situation where an accidental pregnancy brings about an admission of an extramarital affair. Since this could lead to major complications or to divorce, the psychosocial counsellor should be more aware of the problem.

h. Situations Involving Emotional Problems and Social Maladjustment

It would take too long here to detail the numerous situations that might come under this heading. However, often the counsellor encounters situations where there is a need for relaxing the usual approach toward family planning, seeking to find the precise mentality of the clients, and then adapting counselling to the particular "world" in which these people live. For example, think of the mentality of certain delinquents who need a feeling of the

clandestine in order to act effectively; approaching such people with the usual highly tolerant attitude may lead to a highly spectacular failure. Another point to emphasize is the extent to which the "outreach" approach can be justified here.

#### i. Situations of Sexual Adjustment

Here we must deplore the all-too-frequent lack of precise border lines between family planning services and sexual therapy per se. In order to round out their services many family planning centres may be tempted to make out that they supply all these services at once, whereas in reality they cannot back this up with action. Indeed the abilities and training required of a good family planning counsellor are not the same as those required for a sexual therapist. Moreover, the couple wishing help with family planning may not necessarily want sexual counselling, and the most basic respect for the clients demands that we accept them as they are.

Moreover, we are deliberately using the word "adjustment" instead of "maladjustment." This is because family planning counselling is related to sexual adjustment independent of any problem of maladjustment. The highly valued period of sexual adjustment and learning that comes when a couple begin life together should also be the time for a sure method of family planning. The role of the psychosocial counsellor (in addition of course to referring situations of dysfunction to specialists in sexual therapy) will relate the need for family planning to that for sexual adjustment.

j. The Situation of the Physically Handicapped

The psychological involvement here is not so much at the level of the various counselling stages as at the level of a feeling related to a specific means of sexual expression, or fear of having an abnormal child. This means that the counsellor must be able to pay special attention to the phase of decision-making regarding a possible child and also to sexual satisfaction.

k. Situations of Those Living in Isolation

Prison inmates are, of course, the prime example of this situation. However, there are also many other people who for one reason or another spend their lives or parts of them cut off from the rest of society or from their surroundings (the chronically ill, the profoundly retarded, the aged, adolescents in foster homes).

We all know just how difficult the sexual life of most of these people is and it is at this level that most of their problems are found. But these people are also entitled to be able to control their fertility and it is vital that the counsellor know how to take their specific living conditions into consideration to ensure that the minimal sexual life available to these people will at least not be handicapped by the fears related to lack of family planning. The increasingly frequent efforts being undertaken to facilitate the sexual life of such persons must not ignore the fact that the family planning worker must definitely be involved and at a very early stage.

## 12. Situations of Alcohol and Drug Addiction

These situations are more prevalent than is generally believed and they are not likely to decrease. One of their major characteristics is that these addictions bring with them a mental state that risks going totally against the requirements of an enlightened conscience and responsibility that are primary in any family planning action. It will therefore be vital for the psychosocial counsellor to know how to detect these situations and how to adapt his services to clients that are "sober" as well as to the same clients when they are intoxicated and also to exercise a more careful scrutiny at the level of follow-up.

### 1. Situations of Mental Retardation and Other Mental Deficiencies

The peculiarity of such situations rests in the fact that mental problems may be accompanied by such a lack of personal resources that the counsellor cannot count on the client's having even a minimal capacity for self-determination. It then becomes obvious that the phases of psychosocial counselling must be completely modified and that the teaching instruments must be adapted or created from scratch. Either alone or after consulting other professionals in the rehabilitation field, the counsellor must often advise on all decisions -- even very drastic ones -- that concern family planning measures to be taken in such cases.

### m. Situations of Rape and Incest

In many places a considerable sometimes even alarming increase

has been noted in these situations. Obviously we are dealing here with specific, easily recognizable problems. Both types of situations clearly imply troubles with sexual expression, involving the client's referral to a specialized sexual therapist. On the other hand the "victim element" is clearly manifest in these situations, so the family planning counsellor and the client must always take "the third party" into account. For this reason the very specific legal aspects of such situations must equally be considered along with the psychological reactions they produce. Especially in the case of the victim the counsellor must often "undo" the experience that was "unwanted" (or so we presume initially), both with regard to sexuality and to the birth of child. Also the involvement or reinvolverment of the spouse and the reinterpretation of the entire situation with him or her will represent vital moments in psychosocial counselling. It is certain, finally, that particularly clear if not rigid positions must be taken and here more than anywhere else the solution of abortion must not be excluded. In short, the very specific significance of such situations does not allow the family planning counsellor to intervene on his own, although his intervention is primary and he can serve as a catalyst between the parties involved.

This latter situation is the last in our coverage of non-standard situations in family planning. It will surely have been noted that the last situation is on a quite different plane than those preceding it. However, it may be useful for the



perception and identification of the psychosocial elements of family planning counselling and for defining the role the psychosocial counsellor might play in it.

Towards Preparing a Guide for Action and Drawing up the Psychosocial Portion of the Clinical File

Thus ends our effort to define the psychosocial aspects of family planning and to express them in regard to the social worker. The essential elements of this discussion are repeated in the following synoptic table. It should be emphasized that this is a preliminary work whose aim is only to provide a framework for further elaboration of the subject. Perhaps this first attempt provides certain material that can be used in family planning counselling -- material that may also hasten the day when there is a complete guide for the social worker's job in family planning, as well as on the integrated use of the psychosocial section of the client's clinical file in regard to counselling for family planning.

PSYCHOSOCIAL ASPECTS OF FAMILY PLANNING: THEIR  
PLACE WITHIN THE COUNSELLING PROCESS

First approach: elements related to personality	A. Sexual Universe	a. Formation of sexual attitudes
		b. Acquisition of sexual knowledge
		c. Development of sexual motivation and decision-making with regard to sexual life and actualization of sexual behaviour
	B. Marital Universe	a. Level of satisfaction within the marriage
		b. Level of sharing and agreement within regard to the spouses' roles in family planning action
		c. Value of communication between the partners
	C. Universe of the Child	a. Attitudes toward a child
		b. Motivation to have a child
		c. Position in relation to a child
	D. Contraceptive Universe	a. Contraceptive attitudes
		b. Contraceptive motivation
		c. Contraceptive decision and contraceptive behaviour
Second Approach: elements related to social relationships	a. Family relationships	
	b. Professional relationships	
	c. Recreation and social life	
	d. Relationships with relatives	
	e. Material conditions and housing conditions	
	f. Life style and social environment	

Third Approach:  
the process of  
counselling in the  
area of family  
planning

- a. Awareness
- b. Motivation
- c. Individualized information
- d. Choice of method
- e. Perseverance in use of a method

Fourth Approach:  
non-standard  
situations

- a. Unstable sex life
- b. Absolute contra-indication to pregnancy
- c. Irregular reproductive cycle
- d. Sex life "outside the norm"
- e. Substandard living conditions
- f. Marital difficulties
- g. Extramarital sexual situations
- h. Emotional problems and sexual maladjustment
- i. Sexual adjustment
- j. The physically handicapped
- k. Those living in isolation
- l. Alcohol and drug addiction
- m. Mental retardation and other mental deficiencies
- n. Rape and incest

## FOOTNOTES

<sup>1</sup>See the following: Marie Berlinguet, La pratique des travailleurs sociaux du Québec dans les requêtes de stérilisation volontaire, The role of Quebec social workers in voluntary requests for sterilization Toronto: University of Toronto, 1975).

Raymond Boutin, Le travailleur social et le planning familiale, The social worker and family planning Toronto: Canadian Planned Parenthood Federation, (December 1973).

Renée Cloutier-Cournoyer, Interaction conjugale et planification des naissances en milieu défavorisé urbain québécois, Marital interaction and family planning in disadvantaged urban areas in Quebec Quebec: Laboratory of Sociological Research, Department of Sociology, Laval University, 1975).

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Jules-H. Gourgues, "Pour une approche plus complète de la planification des naissances," Toward a more complete approach to family planning Le Médecin du Québec, 10, (April 1975): 45-58.

Mireille Lafortune, Le sentiment de culpabilité et le choix d'une méthode contraceptive chez les femmes, Guilt feelings and choice of a contraceptive method by women (Montreal: University of Montreal, 1973).

<sup>2</sup>E.W. Pohlman, Psychology of Birth Planning, Cambridge, Mass.: Schenkman Pub., 1969).

<sup>3</sup>Gourgues, Sexualité et planification des naissances, pp. 584-612.

<sup>4</sup>Ibid., pp. 118-129, 201-215, 491-495 and 580-585.

<sup>5</sup>Ibid., pp. 119-122 and 579-585.

<sup>6</sup>See these and others:

Murray A. Strauss, Family Measurement Techniques (Minneapolis: University of Minnesota Press, 1969).

The Population Council, A Manual for Surveys of Fertility and Family Planning: Knowledge, Attitudes and Practice (New York: Demographic Division, The Population Council, 1972).

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Family Life Publications Inc., Information about Counselling and Teaching Aids (Saluda, N.C.: Family Life Publications Inc., 1974). (brochure)

<sup>7</sup> Cloutier-Cournoyer, Interaction Conjugale.

<sup>8</sup> Gourgues, Sexualité et planification des naissances, pp. 558-563, 579-584.

<sup>9</sup> See note 6 and particularly:

Quebec Planned Parenthood Federation, "Unto us a child . . ." (Montreal: test set no. 1, 1973) pp. 1-7.

National Organization for Non-Parents, "Am I parent material?", N.O.N. Newsletter, III, (May-June 1975).

<sup>10</sup> Model presented by Françoise B. Lamontagne and developed by the Committee of Workers in Psychosocial Involvement with Family Planning, a committee charged by the Association of Social Service Centres of Quebec (Montreal) with identifying the psycho-social elements of family planning; Report to be published in early 1976 by the Association: "Psychological aspects and social aspects of the four stages of personal behaviour in relation to family planning."

<sup>11</sup> Gourgues, Sexualité et planification des naissances, pp. 601-612.

<sup>12</sup> Françoise Lamontagne, and Jules-H. Gourgues, Identification des besoins communs et spécifiques en planning familial (Identification of common and specific needs in family planning) (Montreal: Family Planning Centre of Quebec, Inc., 1971).

<sup>13</sup> Gourgues, Sexualité et planification des naissances, pp. 136-215.

## ADOLESCENT SEXUALITY: ITS IMPLICATIONS FOR SOCIAL WORK

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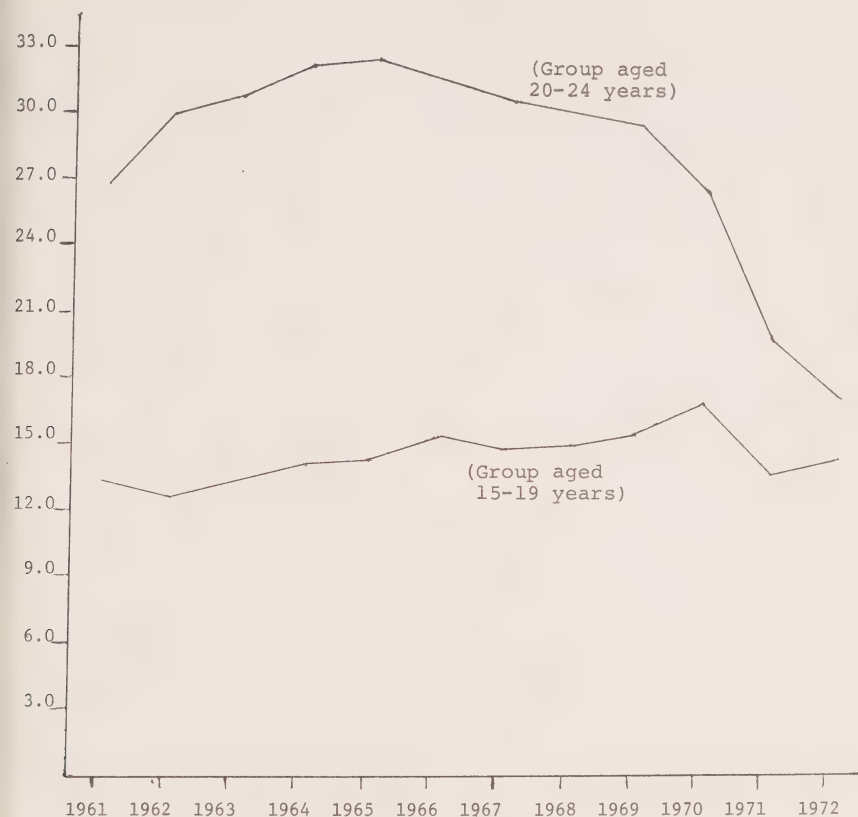
"When adolescents adopt certain beliefs and forms of behavior in response to their sexual desires, we call this adolescent sexuality. Adolescent sexuality is important because it greatly influences what young people think and do in all aspects of their lives."<sup>1</sup> The way in which young Canadians express their sexuality is of great concern to their parents and others in positions of authority. Adolescents no longer accept the idea that sex before marriage is sinful. Increasingly, and at younger ages, they are engaging in sexual intercourse and developing their own value system for sexual behaviour.

Adult values, which are still presented to teen-agers as guides for moral behaviour although little adhered to by older Canadians, set expectations that before puberty children will be non-sexual and innocent and after puberty, totally asexual until marriage.<sup>2</sup> Faced with the dilemma of being moral and having no means of sexual expression or immoral and sexually expressed, they are choosing more and more to disregard traditional values.

Adolescents' behaviour has been influenced somewhat by the advancing onset of puberty - now a little more than 12 years for girls (compared to 17 years some 100 years ago) and about 13 years for boys. Male growth is now complete by age 17 instead of 20 or more and the peak of male virility is reached before age

Rates Per  
1,000 Single  
Women

Age-Specific Illegitimacy Rates  
Ontario, 1961-1972



Source: Research Branch, 1975, Ontario Ministry of Community and  
Social Services

20.<sup>3</sup> Added to this is the influence of prolonged education which results in marriage at a much later age, a median age of 23.5 years for bachelors and 21.3 years for spinsters in 1971.<sup>4</sup>

#### Indications of Sexual Activity Among the Young

Although no national figures are available in Canada on the sexual behaviour of adolescents, there are reliable indicators that there is much sexual activity among those in this age group. The rise in illegitimate births, the increased number of abortions and the higher proportion of young people among recorded cases of venereal disease provide evidence of their sexual involvement.

##### 1. Illegitimate Births

Illegitimate births continued to rise in Canada from the beginning of the 1950's to a peak in 1970 and have declined somewhat since therapeutic abortion became more available.<sup>5</sup> In Ontario, the province with the greatest number of out-of-wedlock births and where statistics are available by age group, the proportion of births to unmarried mothers under the age of 20 years increased from 39.8 per cent in 1950 to 55.7 per cent of the total in 1973.<sup>6</sup>

Although this increase in illegitimate births to teenagers reflects to a great extent the increase in proportion of that age group in the total population during those years, this does not entirely account for the rise in numbers. Age-specific illegitimacy rates for Ontario (rates per 1,000 single women)<sup>7</sup> show a gradual increase in the rate for the group aged 15-19 years



until 1970 and a slight drop thereafter. The graph compares the age-specific illegitimacy rates for the age groups 15-19 years and 20-24 years in Ontario from 1961-1972. It is apparent that in the older group the illegitimate births began to drop after 1965, several years before the change in abortion laws. The explanation likely lies in the increased availability at that time of reliable contraceptive measures to which the teen-age group has not had ready access.

## 2. Abortions

Since the Criminal Code was amended in 1969, to allow for therapeutic abortions in certain cases, such abortions have continued to rise yearly in Canada. The following table demonstrates this increase.

Therapeutic Abortions in Canada  
1970-1973

<u>Year</u>	<u>Number</u>	<u>Per Cent of Live Births</u>
1970	11,152	3.0%
1971	30,923	8.6
1972	38,853	11.2
1973	43,201	12.6

Source: Statistics Canada, Therapeutic Abortions,  
Catalogue 82-211 Annual, p. 7.

Thirty-three per cent of the total number of abortions performed in 1973, in eight provinces reporting and the Yukon, were performed on girls under 20 years of age. Ninety-seven per

cent of these teen-agers were unmarried.<sup>8</sup> This large number of unwanted pregnancies among teen-agers is evidence not only of sexual activity among the young but also of their failure to use birth control measures.

If the number of therapeutic abortions performed on unwed teens were added to the number of out-of-wedlock births to this age group, it is clear that but for the availability of abortion, the number of illegitimate births to teenagers would have continued to rise beyond the peak recorded in 1970 as portrayed in the above graph. Of course, the number of pregnancies conceived by unmarried teen-agers would be even higher if it were possible to estimate the unknown number of girls who so conceive but marry before the birth of their children.

### 3. Incidence of Venereal Disease

The incidence of venereal disease has more than doubled in Canada from 1963 to 1973. Although teen-agers do not form the age group with the highest rate of venereal disease (the age group 20-24 years has the highest incidence) nevertheless the rate rose in the group aged 10-19 years from 27.6 per cent of the total cases reported in 1963 to 38.9 per cent in 1973,<sup>9</sup> although the proportion of this age group in the population at large increased only from 18.9 per cent to 20.7 per cent. This is sad evidence of a public health problem against which adolescents take little preventive action.

Despite this reliable evidence that many adolescents have had coital experience, there is little Canadian research on adolescent sexuality and no national studies. Human sexuality is an area which has been "off grounds" to Canadian researchers until recent years, and adolescent sexuality in particular is a subject not fully recognized and, consequently, not researched adequately.

### Research on Adolescent Sexuality

#### A. Research in Other Countries

A number of national studies with representative samples have been made of adolescent sexual behaviour in other countries. Although the findings cannot be applied directly to Canadian youth, nevertheless they suggest the trends which appear to be common in cultures like our own.

A survey conducted by the Central Council for Health Education in seven areas of Britain, and reported in the British Medical Journal<sup>10</sup> in 1965, found a very low incidence of coital experience among the unmarried boys and girls aged 15 to 19 years who were interviewed. Only 11 per cent of boys and 6 per cent of girls aged 15 to 17 had had sexual intercourse at least once. Sexual experience was more common among the older age group in which 30 per cent of the boys and 16 per cent of the girls had had sexual intercourse. Minor sexual contacts between the sexes started earlier at age 13 to 15 and more than half of both boys and girls had begun petting by age 17.

In this survey, as in later studies, first experience of sex was not usually planned, although there was seldom undue force or persuasion. Of those adolescents with sexual experience, less than one-half of the boys and one-fifth of the girls regularly used some method of birth control.

The journal's editorial commenting on this survey questioned the researcher's recommendation for better sex education, counselling and the provision of birth control services and concluded that, "To give official sanction to such facilities for the unmarried must inevitably promote extra-marital and promiscuous sexual activity."<sup>11</sup>

Later surveys conducted in the United States show a considerably higher incidence of sexual intercourse among teenagers. It is difficult to determine whether the difference is a cultural one or merely a difference arising from change over time. John Kantner and Melvin Zelnik<sup>12</sup> studied a national probability sample of 4,240 girls aged 15 to 19 years who had never married and found that, as of 1971, 28 per cent had had some coital experience. The likelihood of a never-married girl having had sexual experience rose with age from 14 per cent at age 15 to 46 per cent at age 19.

Kantner and Zelnik discovered evidence that premarital intercourse was beginning at younger ages: of never-married girls who were 19 years old in 1971, only 3 per cent had had intercourse by age 15 years, but of those who were 15 in 1971,

9 per cent had had intercourse. They found that more than twice as many blacks aged 15 to 19 had had intercourse as whites - 54 per cent compared to 23 per cent. Sexual experience was inversely related to socio-economic status for both blacks and whites but this was more markedly so for blacks.

Adolescents who had always lived on a farm were least sexually experienced and those in central cities of metropolitan areas most experienced. The proportion of those with sexual experience was also lowest in families headed by a father and highest in those headed by an unrelated woman. Religious affiliation made little difference regarding sexual experience except among protestant fundamentalists, whose levels were low. Those who attended church faithfully had a lower rate of sexual experience than those who did not.

Kantner and Zelnik also investigated the contraceptive practices of unmarried girls 15 to 19 years of age<sup>13</sup> and found that of those who were sexually active, 53 per cent failed to use any kind of contraception the last time they had intercourse and among the youngest group, aged 15, 71 per cent used no method. More than half of the girls believed that they could not become pregnant either because they were too young, because they had sex infrequently or because they had sex at the wrong time of the month. Those who had intercourse more frequently tended to use contraception regularly.

In this representative sample of American girls, the non-poor used contraception at last intercourse more often than the poor. Socio-economic status, higher education of the mother and higher family income were positively related to the girls' contraceptive use. Girls living alone and those in college dormitories had a high level of contraceptive use. Surprisingly, marriage plans did not appear to make a great deal of difference in contraceptive behaviour. The researchers concluded that there was a great deal of occasional use of contraception but little regular use, probably because for most teen-agers sex is "a sometime thing."

A more recent American study with national scope was made by Robert Sorensen<sup>14</sup> in March 1972. Taped in-depth interviews were obtained with some 200 adolescent boys and girls and questionnaires were completed by a representative cross-section of 411 young people. In this sample 59 per cent of the boys and 45 per cent of the girls had had intercourse.

Sorensen explored both the teen-agers' attitudes toward many aspects of sexuality and their actual behaviour. He looked at the various purposes the adolescents identified for sexual intercourse. He found that a large majority disagreed with the idea that the most important thing in a sexual relationship was the sheer physical pleasure. They looked upon sex as a meaningful way of communicating with others and as a way of learning more about themselves. They saw it as a search for new experiences

and as an index of maturity. They agreed that many young people had sexual intercourse because everyone else was doing it, but few felt that they themselves were influenced by others.

A few adolescents used sex as a way of challenging their parents or society at large. Some agreed sex was used as a reward for favours or as a punishment; others as an escape from loneliness or other pressures; still others, simply as a diversion.

Although in general the majority of adolescents had great respect for their parents' opinions, on the subject of sex they had less respect. Their agreement with their parents' opinions on sex lessened as the adolescents grew older. Most felt that their parents were not able to talk freely about sex; they did not discuss their own sexual activities with parents because they considered this too personal.

A majority rejected the double standard of sex for men and women and about half believed that the church taught that enjoyment of sex was sinful. A majority of boys said they would not lose respect for the girl who went to bed with them; they did not believe that a girl should stay a virgin until marriage. Nor did they believe that two people should have to get married just because they want to live together. Most felt that marriage is just a technicality. However, though accepting of premarital sex, they were much less accepting of extra-marital sexual relationships.

Sorensen identified two dominant types of sexual behaviour among adolescents:

1. Serial monogamy without marriage in which two young people have a close sexual relationship of uncertain duration from which either party may depart if he or she desires.
2. Sexual adventurism in which the adolescent moves from one partner to another with no commitment.

More monogamists were girls than boys and more adventurers were boys. Most monogamists believed they loved their sexual partners and they were more likely to use contraception regularly.

Ten per cent of all the female adolescents reported being pregnant at least once (11 per cent of all younger non-virgins and 28 per cent of older non-virgins). These young people as a whole tended to be contemptuous of girls who became pregnant and faulted the girl, not for wanting a baby or for having a baby if she wanted one, but for becoming pregnant if she didn't want one. Only 18 per cent of girls and 30 per cent of boys agreed that a girl should have an abortion if she became pregnant. Most felt she should have the baby and either get married or bring it up herself. Only 5 per cent saw adoption as a solution to adolescent pregnancy. However, three-quarters of the older boys and one-half of the younger boys said they would accept responsibility for helping their girlfriend if she became pregnant.



Despite this feeling of responsibility, only 47 per cent of the sexually active boys reported that they or the girl used some method of contraception the last time they had intercourse. Sixty per cent of the girls said they or the boy used birth control. However, only about a third of the girls used a reliable method regularly.

Some of the reasons given for non-use of contraception included lack of information about where to go for help, lack of birth control services, opposition in principle, lack of motivation, personal carelessness, too much trouble, concern about parents finding out, disapproval of sex partner, belief that the spontaneity of the sex act is hurt, and a belief that birth control is the boy's responsibility. A surprising number of girls -- 30 per cent of all the girls and 46 per cent of the sexually active girls who had not used birth control during the past month -- believed they could not get pregnant if they did not want to.

Sorensen concluded that adolescent sexuality is a natural phenomenon. It is not seen by most young people as immoral in itself. For them, sexual activities have no relationship to morality except in the way they are used.

#### B. Canadian Research

There have been no surveys of adolescent sexuality in Canada which compare with those of Sorensen and Kantner and Zelnik in the United States but several smaller studies give some indication of

trends in this country. One such study by W.E. Mann<sup>15</sup> compared the sexual behaviour of students at York University in 1969 with that of students in previous sex surveys at the University of Toronto in 1968 and Ryerson Polytechnical Institute in Toronto in 1969.

Of the 511 students in the sample at the University of Toronto, the survey showed that 36 per cent of the unmarried respondents had had sexual intercourse at least once and 20 per cent had intercourse occasionally or often. One in 12 of the co-eds had sexual relations often; of these, 42 per cent used birth control pills but 25 per cent used no method of contraception. One in nine of the men surveyed had sex often and of these 14 per cent used no contraception. The survey showed that a large proportion of the students were no longer affiliated with the churches in which they were raised. Almost half cited personal experience as the strongest influence on their attitudes to sex. Only one in seven credited their parents with the main influence and even fewer, the church.

A non-random survey of 164 male students at Ryerson in March of 1969 showed that 66 per cent had had premarital intercourse. More than half of these had first sexual intercourse at or before age 18. The chief reason for abstinence of those who abstained from intercourse was lack of opportunity. A further one in four abstained for fear of impregnating their partner. Less than one-quarter abstained because they believed premarital sex

to be morally wrong. As in the previous study, a large proportion of the students indicated that religion had little influence on their sexual behaviour. The researcher related the students' pragmatic approach to sex to their work experience and to their working-class backgrounds. However Mann questioned this conclusion for he found that the results of his survey of university students at York were not that different.

In a survey of 153 students randomly chosen from the student directory at York University in 1969, Mann found that 51 per cent of the men and 37 per cent of the women had experienced coitus at some time in their life. Twenty-six per cent of the male students and 22 per cent of the women students had had intercourse during the previous three months with someone they dated fairly regularly. While the women tended to have had only one or two sexual partners, more than a third of the sexually experienced men had had three or more partners.

The York students were found to be overwhelmingly urbanized, secularized, and middle class. They had little use for religion. Only about one-fifth attended church regularly. The majority came from Anglo-Saxon backgrounds and lived at home with their parents, with whom they got along fairly well. Only about one-quarter of the students felt their parents had given them adequate sex instruction. Forty per cent felt the instruction they received was inadequate and 35 per cent received no sex instruction. Four out of 10 received no sex education at school.

More than half expressed dissatisfaction with the social codes of Canadian society with regard to premarital sexual relations. Very few felt that church teachings provide a realistic guide for sexual behaviour.

The students' attitudes toward petting, premarital sexual intercourse, and homosexual relations were quite permissive, although only one per cent admitted having had homosexual relationships. Three-quarters of the students had gone steady at least once but only slightly more than half were going steady at the time of the survey. About one-fifth said that fear of pregnancy prevented them from having intercourse. For those who were sexually active, intercourse was most likely to occur in a friend's home, in their own home or in a car.

Some 30 per cent of the males and 27 per cent of the females had used contraception. About one-half felt that their sexual relationships had been both satisfying and happy. While 42 per cent of the sample admitted they had experienced some guilt over their sexual behaviour, 50 per cent claimed they felt no guilt or shame.

Mann found the students at York to be substantially more permissive in sexual attitudes, norms and behaviour than the students he had surveyed at the Universities of Western Ontario and Calgary some four years earlier. He suggested this may indicate a strong movement toward increasing permissiveness among university students, and particularly among women students.

His results compared closely to those of similar studies in New York and Cambridge at that time.

In a recent study in Kingston, Ontario, by J.M. Howard and N.G.H. le Riche<sup>16</sup> during the summer of 1974, a sample of 466 adolescents between 13 and 19 years of age was surveyed in shopping plazas and public places where teen-agers congregate. Using a self-administered questionnaire, the study investigated the proportion of adolescents engaging in coitus, those engaging in unprotected intercourse, their knowledge and use of contraception, and their attitudes toward abortion and sex education.

Nearly half of the adolescents surveyed had had sexual intercourse at some time. Their response to the question, "Have you ever had sexual intercourse?" varied considerably by age and sex as follows:

	<u>Age</u>	<u>Yes</u>	<u>No</u>
Females	13-15 years	26.0%	74.0%
	16-19	47.9	52.1
Males	13-15	43.1	56.9
	16-19	72.3	27.7

This resulted in an average of 37.0 per cent of the girls and 57.7 per cent of the boys with coital experience. Among both boys and girls this experience increased with age and grade level. Those living away from home were significantly more likely to have coital experience.

Of the sexually experienced group, approximately three-quarters reported they had had intercourse at some time without contraception and 48 per cent of the boys and 29 per cent of the girls used no method of contraception at last intercourse. A majority of the boys expressed some concern that the girl might get pregnant, but this concern was more evident among the older boys.

The adolescents were asked the reasons they had not used contraception and their responses are listed below:

I thought it was unlikely that I (or the girl) would get pregnant.	57%
I didn't think I was going to have sex at that time.	57%
Neither of us thought it was necessary to use a contraceptive.	51%
By having a contraceptive available, it would have appeared to my partner that I was planning to have sex.	50%
Except for birth control pills, most other methods are just too much trouble to use.	43%
I was too embarrassed to go to the doctor or drug-store to get something to prevent pregnancy.	33%
I didn't use a contraceptive because I was afraid someone might find it.	25%

An astounding 83 per cent of the girls 16-19 years of age thought it was unlikely they would get pregnant. It may be that they were operating on a rhythm system and believed they were in their "safe" or infertile period. Of the boys, 71 per cent agreed that they hadn't used a contraceptive because it would appear they were planning to have sex. This was of far less concern to the girls.

The older teens had a better knowledge of the effectiveness of birth control methods. The methods most commonly used by

the boys were condoms and withdrawal. Some 40 per cent of the sexually active older girls and 14 per cent of the younger were using the pill, although more had used it at some time. Those taking the birth control pill had significantly more coital experience than those who were not.

Nearly 90 per cent of the teenagers had had sex education in school, although a smaller proportion said methods of preventing pregnancy had been discussed. Nearly all agreed that contraception should be discussed in class.

These young people were rather conservative in their attitude toward abortion. Less than half (43 per cent) agreed that anyone who wants to have an abortion should be able to have one. Boys were more liberal than girls. The vast majority disagreed with the statement that since abortions are easy to get, they did not need to use contraception.

The significant findings of the Kingston study were that while nearly half of the teen-agers surveyed were sexually active and knowledgeable about contraception, a large proportion did not use a reliable method regularly.

In a study of 112 pregnant girls aged 14 to 19 years, conducted by the author in the Family Planning Clinic, Department of Health, Borough of Scarborough in Metropolitan Toronto in 1972, it was found that nearly all the girls had a very permissive attitude toward premarital sexual relationships. Although a few

said there were no circumstances under which they disapproved of premarital sex, three-quarters felt it was wrong if there were no meaningful relationship. A further one in 10 disapproved if the girl were promiscuous. The need for a loving relationship was prominent in most responses to the question, "What do you think about having sexual relations before marriage?" For example:

The couple should be in love. Not just for pleasure. I don't agree with that.

It depends. If you've been going together a long while and really care it's O.K. If you don't know or love him it's wrong.

It depends on the people themselves. It's O.K. if they are mature enough to handle it and they can't get married.

It's all right as long as you really love each other.

Well, I don't think it's really good but it happens. There should be love.

Almost all of these girls knew a number of other girls who had been pregnant. A fifth of the sample had known seven or more pregnant girls. Although the vast majority thought older people were rejecting in their attitude toward unmarried pregnant girls, only one-fifth thought their peers were rejecting. They commented:

Teen-age friends would understand. Girls who see a different guy all the time who get pregnant; it makes me sick.

or:

Neighbours, older people, it depends on who they are. Some think it's a terrible thing to happen. Young people - they accept it. It's nothing unusual. It happens all the time.



All but four of these pregnant adolescents had a family doctor but seven out of 10 said they would not feel free to go to their doctor for information about sex and help with birth control. Of those who would not seek their doctor's help, more than half feared that he might tell their parents. Another large group said they were uncomfortable and unable to talk to the doctor. Although more than a third said they would feel free to talk to one of their parents about getting contraceptives, 60 per cent said they could not do so.

In spite of the fact that 70 per cent said they did not want to have a baby when they conceived, 77 per cent used no method of birth control at the time of conception. Almost half had never used contraception of any kind. They gave a number of reasons for this failure to protect themselves but the most frequently cited reason was their inability to believe that they could become pregnant. A 16-year-old girl who used no method explained.

I just didn't think it would happen to me. The doctor told my mother because my periods were irregular, there wasn't much chance of me getting pregnant. I knew about the pill and safes. That's about all. I heard the pill was the best. It wasn't for very long I was having sex. I wouldn't have known about where to go to get it (birth control). I knew about the clinic but I didn't know what I would have to do at age 16 to get it. And then I just didn't think it would happen to me.... I didn't have any sex education really - a little at school in grade nine. Just a vague course on the male and female body. Nothing on birth control or pregnancy or sexual intercourse that I remember.

A 15-year-old stated:

I didn't think I needed it (birth control) because I don't go out with that many guys. I'm not allowed to.... I didn't want to have a baby at this time, not until I'm older. I still have to go to school.

A girl of 17 who had discontinued using the contraceptive pill reported:

It was fine on the pill but my parents didn't know I was still seeing him so I decided to get rid of all evidence. I had been on the pill six months. I didn't know you were more likely to get pregnant if you went off.

He had safes but he didn't use them at the time.... He was using withdrawal. He had used it before and it worked. I thought it would be O.K. I didn't worry about getting pregnant.... No, I didn't want to get pregnant.

Nearly 70 per cent of these adolescents had a relationship with the boy who impregnated them of at least six months duration and 46 per cent of more than 12 months. Eight out of 10 said they had a close or a very close relationship. They were typical of the teen-agers Sorensen described as "serial monogamists."

A much higher proportion (63 per cent) of these pregnant adolescents approved of abortion than was reported in other studies but perhaps they were influenced by their own difficult situation. In this sample a girl's attitude toward abortion was very significantly related to the decision she made about her pregnancy: whether to abort or to carry ( $p = 0.0000$ ).

As in previously described studies, these teen-agers showed a high degree of secularization. Although 82 per cent

claimed an affiliation with some religious organization, 52 per cent never attended church and only one in 10 attended regularly. They did not differ greatly from their parents, more than half of whom were said never to attend church. Oddly enough, a majority of the sample considered themselves somewhat (57 per cent) or very (8 per cent) religious in spite of the fact that more than half said their religious training had no effect on their behaviour.

#### Common Findings from Research

From the studies reviewed and the literature on adolescent sexuality a number of common findings emerge.

##### 1. Increased Permissiveness

Recent studies show an increasing permissiveness in the attitude of adolescents toward sexual activities prior to marriage. They no longer accept the concept that enjoyment of sex is sinful or that it should be restricted to marriage. They appear to be developing a new moral code for sexual behaviour which differs significantly from the traditional one.

This change is ascribed to a number of factors: a decrease in the authority of the family with a concurrent increase in the influence of peers; a decrease in the influence of the church and increasing secularization of the young; an increase in the influence of the mass media by which sex is used to promote everything from tooth paste to automobiles and by which nudity and illicit sexual behaviour are openly portrayed; and finally, an

increasing idolization of youth and novelty as opposed to age and wisdom.

## 2. A Willingness to Accept Risk

Nearly every study of adolescent sexual behaviour gives evidence of a lack of use of contraception among sexually active teen-agers. Although boys express concern about impregnating their sexual partners, relatively few use any reliable method to prevent conception. Among girls there exists a nearly universal fantasy that they will not become pregnant. "It can't happen to me" is their most common response to their own vague concern and that of their boyfriends that they might become pregnant.

This irresponsible and illogical behaviour is both difficult to understand and to deal with effectively. While some teen-agers show a lack of precise knowledge about contraceptive measures, for the most part they are well informed but take no appropriate action. This same thinking seems to apply with regard to sexually transmitted diseases. While most teen-agers have heard about VD, they do not expect to contract such a disease and, consequently, take no action to prevent it. They regard it as something that happens to someone else but not to them.

## 3. Lack of Communication between Parents and Children about Sex

There is nearly a universal inability of parents to discuss sexual matters with their children. They find it difficult to accept the sexuality of their maturing teen-agers and cannot deal with the

conflicts which arise from the changed moral codes. Unused because of their own restricted upbringing to discussing sex openly, they cannot provide the information and guidance their children require. Indeed, many parents are less well informed than their children about the physiology of sex and methods of contraception.

On the other hand, their children, having reached a stage where they wish to establish an identity and a life separate from their parents, are loathe to discuss personal matters with them and prefer to share their intimate thoughts and experiences with their peers or not at all. Part of their reluctance to discuss sexual matters with parents arises from their fear that parents will jump to conclusions about their sexual behaviour, will make unfavourable moral judgments and will be displeased, disapproving and even angry. Perhaps a larger part is due to their very real need to keep this particular part of their life confidential and hidden from their parents.

One wonders if this very common and natural reluctance on the part of both parents and children is connected to the universal incest taboo. Perhaps the need to prevent incestuous relationships requires them to avoid all relationships pertaining to sex.

Unfortunately, the adolescents' inability to discuss sexual concerns with their parents extends to other persons in positions of authority and, in particular, to family doctors who

might otherwise be the most appropriate persons from whom they could seek help. This transference prevents many teen-agers from obtaining needed help to prevent pregnancy and venereal disease.

#### 4. Inadequate Sex Education in Schools

Since parents are unable to deal adequately with the sex education of their children, schools might have been expected to accept this role. However, study after study indicates that this is not the case. Adolescents report that they had no sex education or too little too late.

School boards are reluctant to approve curricula that include such contentious subjects as birth control, abortion, masturbation and homosexuality. Parents fear that the provision of information on such subjects will indicate that they condone premarital sex and will encourage promiscuity. Teachers, who like parents are uncomfortable about discussing sexual material and are poorly prepared to teach it, for the most part are not willing to provide meaningful courses. Those teachers who are well informed and able to discuss sex, are frequently prevented from doing so by fears of adverse parent reactions or by restrictive board policies.

Nevertheless, teen-agers over and over express a desire for more sex education, for better courses which include discussions of feelings, attitudes and values as well as male and female anatomy. And they ask for more timely courses, -- that is, earlier in their

schooling before they become physically involved with the opposite sex. They also express a desire for their parents to be educated in this area and for parents to accept the responsibility for educating them.

##### 5. Lack of Access to Birth Control Services for Adolescents

Studies of adolescent sexuality indicate that teen-agers do not have ready access to birth control services. Research has shown that many doctors will not provide birth control for minors without parental consent. This refusal is sometimes based on the doctor's own moral code which does not permit premarital sex or on a fear of legal liability for treating minors without their parents' knowledge and approval.

Across Canada the laws on age of consent are both restrictive and confusing. Teen-agers do not have the right to be treated in confidence. Private physicians who provide birth control measures to minors are not protected by law.

Concern about a lack of confidentiality and a judgmental attitude on the part of professionals prevents teen-agers from seeking help. Medical facilities such as family planning clinics, which provide anonymity, confidentiality and "hassle-free" service are almost non-existent except in large urban centres. Where these facilities do exist they are often poorly advertised and sometimes held in locations that are difficult to reach for many teens, and at times that are inconvenient.

The overall picture which emerges in regard to

adolescent sexuality is one of increased sexual involvement of adolescents, a consequent increased need for service, and a failure of parents and the community to respond to this need.

#### Implications for Social Work Practice

Now that nearly one-half of unmarried adolescents in some Canadian urban centres are sexually involved, social workers must no longer consider premarital coital experience as deviant behaviour and evidence of psychological pathology. Premarital intercourse has become the norm for many teen-agers though not for all. It is almost universally viewed by adolescents as a mode of behaviour which is open to them should they so choose.

It behooves social workers to meet the needs of adolescents for services, needs which arise from this change in moral code and mode of behaviour, in order to prevent the harmful consequences which might result: unwanted pregnancy, abortion, social disease, and parent-child conflict. Several courses of action for social workers are suggested:

1. The Provision of Sexual Counselling and Information on Birth Control to Young Clients

In their work with adolescents, social workers should be prepared to introduce the subject of sexual behaviour and to provide accurate information on methods of birth control and prevention of venereal disease. Teen-agers are often reluctant to initiate discussion in this area but are anxious to talk to a knowledgeable, non-judgmental, unembarrassed person if given the opportunity.



They need to discuss their feelings and fears but will not avail themselves of the opportunity unless they are assured their discussions will be held in strict confidence. A feeling of mutual trust is basic to this kind of discourse. Social workers must assure their young clients the same confidentiality that is accorded to adults.

Social workers should feel free to discuss their own values with teen-age clients and to acknowledge that their values differ. Workers may express approval of the positive attitude of the young toward human sexuality but express concern about their involvement in sexual activities at increasingly earlier ages. Young clients may need another set of values against which to test their own developing ones. The pressure from peers to conform to their standard of behaviour may be intimidating. Not all adolescents wish to be involved sexually, some because their own standard does not permit it and others because they are not ready emotionally for such intimacy. They require support in their decision to remain chaste.

Teen-agers require not only counselling and information but also referral to medical help -- either to community clinics or to sympathetic private physicians who will provide the service they need without imposing obstacles. For adolescents who are self-conscious and uncomfortable about seeking medical help, the social worker must provide accompaniment, emotional support and

follow-up services as necessary.

## 2. Counselling of Parents with Adolescent Children

Many parents have great anxiety about the sexuality of their adolescent children. They fear that if their children become sexually involved, somehow they have failed as parents. If their children become pregnant or contract a venereal disease, they blame themselves and consider themselves "bad" parents and their children "bad" children. They are concerned as well about what the community and their relatives will think of their children's behaviour and of their own efforts as parent. They require help to see their children's behaviour in the context of society at large and the changes that have occurred in sexual mores since they were young.

Parents frequently feel inadequate because they lack knowledge on physical anatomy, human sexuality, birth control and venereal disease. They cannot teach their children what they do not know themselves but they are too uncomfortable to talk about it. Like their children, they need the opportunity to discuss these matters in private with a social worker and in groups with other parents. They may need to discuss their own problems around sexual relationships before they can deal comfortably with the problems of their children.

Social workers should be prepared to provide informed, unself-conscious counselling for parents with adolescent children.

The simple technique of helping them to talk about it may often relieve their anxiety, increase their comfort and enable them to cope with their parental responsibilities.

### 3. Self-development and Education

Most social workers feel a need for further knowledge in the area of human sexuality, an area which was most likely neglected in their professional training. Like other adults, they need to increase their comfort in discussing matters related to sexuality. This requires developing an awareness of their own attitudes and fears about sex. This can best be done by attending courses and workshops especially designed for this purpose. Although few such courses have been available which are specifically oriented for social workers, now a number are being offered across the country by professional schools and associations, government departments, universities and community colleges.

Social workers should encourage the development of such training opportunities, participate in programs for self-development and accept the responsibility for contributing to the training of others.

### 4. The Development of Agency Policies and Services regarding Human Sexuality

There is a great need for social agencies to review their policies, or lack of policies, in the area of human sexuality. The development of clear and unrestrictive policy statements and guidelines

for practice would be of invaluable assistance to social workers in providing counselling and information on human sexuality. Workers will not feel free to provide help to adolescent clients unless they have the approval of their board and their administrators.

An agency policy statement alone will not ensure the provision of necessary services. There must be a commitment of funds for the provision of in-service training programs and for attendance at courses and workshops to assist the workers in developing the required skills.

#### 5. The Development of Social Policy and Programs for Adolescents

Through their individual efforts and through their professional associations social workers should encourage governments at all levels to meet the needs of Canadian youth. They should request amendments to legislation concerning the age of consent for medical treatment so that medical practitioners may prescribe birth control measures for sexually active adolescents without fear of legal action. They should support sex education programs in schools and government-financed programs to provide medical and counselling services for the young.

#### Conclusion

While social workers cannot alter the trends toward change in sexual mores and behaviour of adolescent Canadians, they can

help to lessen the harmful effects that may accompany these changes such as unwanted pregnancy, venereal disease and family conflict. The onus must be on social workers to take the leadership in helping develop needed services for teen-agers and their families -- services which include sexual counselling, information on birth control and venereal disease, and the provision of related medical care.

#### FOOTNOTES

<sup>1</sup>Robert C. Sorensen, Adolescent Sexuality in Contemporary America (New York: World Publishing, 1973), p. 3.

<sup>2</sup>Warren R. Johnson, Human Sexual Behaviour and Sex Education (Philadelphia: Lea and Febiger, 1968), pp. 62-63.

<sup>3</sup>Carol A. Cowell, "'Rap' with the Adolescent," Medical Aspects of Human Sexuality, 3, (October 1973): 4.

<sup>4</sup>Statistics Canada, Canada Year Book, 1973 (Ottawa: Information Canada, 1973), p. 201.

<sup>5</sup>The amendment to the Criminal Code with regard to abortions became effective in July of 1970. Under this measure a woman may obtain a therapeutic abortion if a hospital committee of three medical doctors decides that her life or health is in danger.

<sup>6</sup>Province of Ontario, Vital Statistics for 1969 (Toronto: Queen's Printer, 1971), p. 20, Table G; also Vital Statistics for 1973 (Toronto: Registrar General, 1974), p. 15, Table G.

<sup>7</sup>Robert E. Youtz, Trends in Illegitimacy in Ontario (Toronto: Province of Ontario, Ministry of Community and Social Services, Research Branch, 1975). Unpublished.

<sup>8</sup>Statistics Canada, Therapeutic Abortions, 1973. Catalogue 82-211 Annual (Ottawa: Information Canada, December 1974), p. 10. Note that statistics are not available for Ontario and British Columbia, the two provinces reporting the greatest number of therapeutic abortions.

<sup>9</sup>Statistics Canada, Annual Report of Notifiable Diseases, 1973. Catalogue 82-201 Annual, pp. 40-41; and Annual Report of Notifiable Diseases, 1963.

<sup>10</sup>Editorial, "Sexual Behaviour of Young People," British Medical Journal, London, 31 July 1965, Vol. 2, No. 5456, p. 247.

<sup>11</sup>Ibid., p. 249.

<sup>12</sup>John F. Kantner, and Melvin Zelnik, "Sexual, Contraceptive and Pregnancy Experience of Young Unmarried Women in the United States," Family Planning Perspectives, 4, (October 1972), reprint, pp. 1-10.

<sup>13</sup>John F. Kantner, and Melvin Zelnik, "Contraception and Pregnancy: Experience of Young Unmarried Women in the United States," Family Planning Perspectives, 5, (Winter 1973), reprint, pp. 11-25.

<sup>14</sup>Sorensen, p. 3.

<sup>15</sup>W.E. Mann, "Sex at York University," in Social Deviance in Canada, ed: W.E. Mann (Toronto: The Copp Clark Publishing Company, 1971), pp. 366-379.

<sup>16</sup>J.M. Howard and N.G.H. le Riche, A Survey of Teenage Attitudes to Sex and Contraception in Kingston (Kingston: Queen's University, Faculty of Medicine, 1975).

## SOCIAL WORKERS AND SEX EDUCATION:

### A QUEBEC EXAMPLE

Jules-H. Gourgues, M.S.W., M.Sc. F.S.

Like most other modern states, Quebec in the 1970's has had to face growing problems in the area of sexuality and family planning with regard to its young people. Sophisticated statistics<sup>1</sup> are not needed to demonstrate the recent increase in premature or unwanted pregnancies, venereal diseases and abortions among young people--in short, all problems related to a lack of sexual education including family planning. In Quebec, as elsewhere, these social problems require public administrations to intervene both responsibly and energetically.

#### Social Responsibility

Backed by eight years of involvement in the family planning field, the Quebec Department of Social Affairs felt that, in the absence of a comprehensive sex education program, it should do everything it could to respond to the problem. Basing its decision on the 1972 departmental statement of principle regarding family planning<sup>2</sup> and influenced by many representations on the subject (particularly from social workers and school nurses), the department resolved to implement a province-wide high-school information program.

The program was designed to supply senior secondary



school students with a minimum of contraceptive and sexual information, to foster a better understanding of their relationships with the opposite sex and enable them to ascertain both what conditions are necessary for proper relationships and what personal responsibilities are involved.

### The Major Objectives

The objectives in detail are numerous. The most easily identified are the most concrete and involve the most problems: to decrease difficulties--unwanted or premature pregnancies; venereal diseases, and abortions--that social and health professionals in the schools deplore. These professionals also deplore being left alone to face such problems. It was hoped that energetic measures as free as possible from such things as administrative slowness, political constraints and ideological double-talk, would spare young people in Quebec from problems confronting youth in many areas today or at least lessen their problems somewhat.

In addition to this, the program's main preventive aim is to make Quebec parents of 1985 more aware of the values and directions of the departmental policy regarding family planning:

- That it is the most basic responsibility and the most legitimate right of sexual partners to have children under the best possible physical, material, psychological and social conditions.
- That it is the duty of every sexually active person

to realize that society or one's family may reject an unwanted child.

- That planning births is a vital ongoing function and therefore should not be seen solely as a medical situation without strong psychological components.
- That a citizen has a right to insist that the government make as accessible as possible needed medical and psycho-social services in this area; it is also his responsibility to become familiar with them and know to use them.

In short, this is a true preventive and educative goal for it is not incongruous in the least to juxtapose the terms "education" and "family planning."

The program has other objectives as well. It is intended to counteract the vicious circle (a problem even for the most developed countries) of family planning in disadvantaged areas: "large family = poverty; poverty = large family". This incongruity exists in Quebec as elsewhere: the people with the most children are also often those with the least material and psychological capacities to deal with them.

At this level the involvement becomes the deepest. How can contraceptive information be more than a band-aid measure if it cannot be provided before a couple has had four or five children or one or two unwanted pregnancies, before they become

perpetually dependent on welfare, before a couple marries too young or enters a "forced marriage", or even before young people become sexually active although totally uninformed about contraception? The only real way of doing this is through prevention. The school is the last organized environment in which disadvantaged youth can be informed in a structured and scientific way before going out to work. This latter objective, then, aims to attack poverty--that perpetual grey area of family planning.

#### An Integrative Approach

These objectives should be part of any family planning action. How can every child be a wanted child if no steps are taken to make this possible before arrival of a first, second or third child? How can we speak of the fundamental right of each couple to choose the number of children they want if contraceptive services are not equally accessible to all? How can the sexual self-realization made possible by family planning be enhanced when it is accessible only to partners in stable relationships? How can newlyweds have some time to get used to their new relationship if they do not know how to avoid marring this fundamental stage by an unwanted pregnancy early in their marriage?

#### A Bird in Hand...

The high-school information program does not, of course, represent an ideal response to the need for a comprehensive program of sexual

education. However, it seems to the department that even a limited response, if immediate, would avoid leaving young people with no help in solving these serious problems while waiting for such a program to be developed. This in itself appeared to us to compensate considerably for the less than ideal character of the program.

#### Program Content

Quebec educational policy requires a nurse and social worker from the social affairs network to provide services in secondary schools through a service contract with the school board and within the structure of the student service program. It is, therefore, recommended that these two professionals work jointly on family planning information sessions for small groups of students in their final year of a vocational course. These sessions take place in the school either during or after school hours. At the students' request, the program particularly emphasizes the following topics: anatomy and physiology, puberty, the menstrual cycle, gynecological examination, sexual relations and family planning. The department has made a slide presentation entitled "Sex: a Masculine and Feminine Noun" available to the nurse-social worker team.

After the information is presented to the students, the professionals answer all questions from them. Then information is given on local resources and the young people are encouraged to continue the dialogue with their parents or persons associated

with these resources.

Because it has always been Quebec family planning policy to go beyond the medical and technical aspects of contraception<sup>2</sup>, the program also provides information on psychology and the emotions of the young, although within the jurisdictional limits that result from the fact that the role of this department is mainly in the realm of information, prevention and counselling. In order to avoid restricting family planning information just to knowledge of contraception, an effort was made to see that the psycho-social elements of family planning, such as consideration of the child, were included as an integral part of the program.

#### Involvement of Social Workers

Since the program is the joint responsibility of the nurse and the social worker, both must participate in the presentation of the program and the audio-visual material; each session is a team presentation. Why is there such a stipulation? One of the main points of the department's policy regarding family planning is, as we said before, that we must avoid considering it as a strictly medical question. In the eyes of the government any involvement in the field must give proper place to the psycho-social elements; this is considered a priority. The departmental policy in this area only reflects what has always been a characteristic of the history of family planning in Quebec.<sup>4</sup>

Such an orientation dictates a very precise policy guideline. Among other things it assumes that it is desirable to change the false impression so often given young people by their parents: the idea that medical care and the prescription of an effective method of contraception is the "be-all" and "end-all" of family planning. The people behind the program felt that an effective way to accomplish this would be to see that the student is aware from his first group session that the program includes a specialist in the psycho-social area of family planning. In this way the student would have more chance of taking into account both the psycho-social and medical aspects of family planning. This also helps to let students know that they can consult the social worker as well as the nurse when they need counselling. We must also add that during the discussions before the audio-visual material was developed, the students confirmed that if they had problem of this nature the majority of them would go to the nurse and the social worker for counselling.

We would be wrong in thinking that the repercussions of such a direction for the program concern only the students. Even though in the beginning it was not always easy to see the activities of the program as relating to both professions--the training sessions, for example--it must be noted that initiation of systematic co-operation between the two professions also does much to develop their own awareness of the field, its multi-disciplinary requirements and the aspects best left to the other

member of the team.

Another indicator of the concern for giving priority to this psycho-social-medical orientation is that the program is carried out under the responsibility of the 14 social service centres in the province. Each of these centres has hired a regional coordinator to direct and facilitate the work of the nurses and social workers within the program.

#### Starting with Consultation

The program presented to the departmental executive<sup>5</sup> was drawn up through consultation with and recommendations from 193 nurses and social workers working in the school system. Some 100 students were also consulted during the production of the audio-visual material<sup>5</sup> and some also cooperated in pre-testing the slide presentation, which in turn led to a video presentation of their reactions to it. The program was then used experimentally in three different school systems and presented to 20 experimental groups composed of parents, students at different levels, specialists in sex education, parish priests, members of family movements, school trustees and students with learning disabilities<sup>6</sup>.

#### Parental Co-operation

One important point: the student's parents have the last word on accepting the program. In fact, before being presented to the students the program is submitted for the approval of school authorities (trustees, school board administrators, professionals and school administrators) as well as of various parent groups and

interested parents of teen-agers who would be included in the session. The department in no way wishes to impose its program on students; any student whose parents request it is exempted from the program, since the department respects the parents' primary responsibility for the education of their children.

#### Training and Evaluation

For the purposes of this program the Department of Social Affairs organized four training sessions<sup>7</sup> for social workers and nurses in the school system. Two 15-hour sessions and two 45-hour sessions enabled the department to involve more than three-quarters of the professionals involved in the program. There was also considerable emphasis on close evaluation of the program<sup>8</sup>. Reports at this level confirm that the program does help the students; it encourages them to take greater responsibility (rather than to become more active sexually), informs them or clarifies information they already have and provides them with the opportunity for a serious exchange of views with their parents.<sup>9</sup>

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In 1975 the program was in its second year in 13 of the 14 social regions of Quebec. The work already done indicated that it is far from easy for a government department to hold a dialogue with young people who have their own views especially when this governmental action must be totally sanctioned by the adult world with its own particular views, and within a society undergoing great change and becoming more and more pluralistic.



The fact that the program has fairly generally satisfied the students and has been either totally supported or severely censured by the adults confirms the belief that this action by the government is not without significance in the development of social policy in Quebec and in the development of our society in general.

## FOOTNOTES

<sup>1</sup>Robert Boucher, Jacques Blouin, and Laurent Marcoux, "Etude sur la sexualité des cégépiens" (éducation régulière et éducation aux adultes), Cegep de Limoilou, {A Study of the Sexuality of Cegep Students (Regular Education and Adult Education), Limoilou Cegep} , Québec, à publier (titre définitif à déterminer).

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<sup>2</sup>Claude Gastonguay, Orientations en matière de planification des naissances {Trends in Family Planning} Quebec: Department of Social Affairs, May 10, 1972.

<sup>3</sup>Robert C. Sorensen, Adolescent Sexuality in Contemporary America, New York: World Publishing, 1973.

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<sup>6</sup>Jules-H. Gourgues, Programme d'information préventive en milieu scolaire (Etat du programme au 1er juin 1973) (High-school Information Program (Progress Report as of June 1973)), Quebec: Department of Social Affairs, June 1973.

<sup>7</sup>See session programs:

- A. Family Planning Training Program, Department of Social Affairs, Quebec, March 23-26, 1973.
- B. Family Planning Program, Department of Social Affairs, Montreal, March 30 - April 2, 1973.
- C. Training Session in Professional Information and Group Leadership in Family Planning, University of Montreal, Montreal, August 12-21, 1974.
- D. Professional Information Session of Fertility and Family Planning, University of Sherbrooke, Sherbrooke, August 13-22, 1975.

<sup>8</sup>See chapter

<sup>9</sup>Marcel Giner, Evaluation du programme d'information préventive en milieu scolaire: la planification des naissances dans Lévis, Laval et Duvernay. (Evaluation of the High-school Information Program: Family Planning in Lévis, Laval and Duvernay), Québec: Department of Social Affairs, July 1974.

## A HIGH SCHOOL FAMILY PLANNING INFORMATION PROGRAM

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Since 1973 the Quebec Department of Social Affairs has been offering a family planning information program to final-year students in public secondary schools in the province of Quebec. This program has provided an unparalleled opportunity for parents and school authorities to develop an awareness of the needs of our adolescents. It gave social workers and nurses an opportunity to develop new skills in the area of family planning. Although it has become evident that this controversial program will never be applied as intended, in many ways it remains a highly valuable and profitable initiative.

Since Jules-H. Gourgues of the Quebec Department of Social Affairs has given a detailed description of the program in his article included in this book, I will limit myself to providing details concerning its application, and to the reactions of certain groups.

To recall briefly some elements of the social and professional context within which this program was to be applied, official statistics indicate that in 1972 adolescents accounted for a third of venereal disease cases, a third of illegitimate births, and a third of the therapeutic abortions performed. Adolescents do not generally have easy access to the kind of information on sexuality likely to increase their sense of responsibility. With

a few exceptions, Quebec schools do not offer any structured sex education courses. Moreover, not all parents are sufficiently informed themselves or sufficiently at ease with the subject to discuss it with their children and provide them with basic scientific facts. If one wanted to paint a general picture of the problem of Quebec adolescents, one might say that they hear a lot of talk about sex, but rarely from people who are in any way responsible for them.

From the professional point of view, school social workers have accepted the responsibility for carrying out the family planning information program in their schools. In Quebec for several years now the profession has been aware of the psychosocial dimension of family planning. The tradition in family planning services has grown up around the recognition that the psychosocial dimension is as important as the medical one.

#### Implementing The Program

The social service centres of Quebec accepted the responsibility for seeing that the program would be applied for their regions through their respective in-school social services. In Quebec there are 14 social service centres. These consolidate and administer all social services in their respective areas except those dispensed by the local community service centres. To coordinate action within the schools and assume certain roles in

carrying out the program, the social service centres have hired additional staff called "program officers," recruited from among social workers and sex counsellors.

Except for a few school boards in Montreal and one of its suburbs, the program officers began to apply the program simultaneously across the province in the fall of 1974. They first made individual contact with the school nurses and social workers who would be called upon to carry out the information sessions. With the help of the social workers and nurses, the next step was to make the community aware of the program. (Here "community" includes school administrators, parents and school boards.) The objective of this awareness was to make those involved conscious of the need to offer information to the students and to make the "in-school" program known as a valid response to this need. After the awareness stage was reached and community agreement obtained, it remained for the nurses and social workers to determine modalities for the information sessions (i.e., number of students per group, best period of the day, themes to be covered, number of times to meet).

In order to treat the reactions of various groups to the information program in the clearest way possible, they are dealt with under separate headings. They include reactions of the Quebec Department of Education, of school administrators and teachers, parents, the general public and a group of students.

a. Reaction of the Quebec Department of Education

The Department of Education in Quebec has existed only since 1973. Previously there was a "department of Public Instruction." It disappeared when the Department of Education was formed, giving way to two denominational committees: Protestant and Roman Catholic. These have absolute power within the department; they approve all programs, manuals and teaching material used in schools of their denomination. In Quebec all public schools without exception are denominational -- either Protestant or Catholic.

In June 1974 the Roman Catholic Committee forbade the school boards to use the Department of Social Affairs' program and, more specifically, severely criticized the audio-visual portion of it. In December 1974 it was again stated that the program could not be used in the Catholic schools. In April 1975 the Department of Education declared in turn that the program had not received either its approval or that of the two denominational committees and therefore could not be used. It added -- and this is important to note -- that it would soon supply a list of written documents and audio-visual aids to school boards wishing to provide sex education.

b. Reactions of the School-Authorities

School boards that were offered the Department of Social Affairs' program unanimously recognized that the students did need to be

informed about their sexuality. On the other hand they considered that the program information was insufficient to develop an increased sense of sexual responsibility among the students and should consequently be rounded out at various levels by courses on the moral, emotional and human aspects of sexuality. Some schools boards were particularly of the opinion that the slide presentation included in the information program was concerned too much with the biological aspect of sexuality and ignored the other dimensions.

c. Reactions of Parents

Program officer met with 500 to 600 parents in some 15 school boards in my region. All the parents agreed to the need for sex education but felt that they were primarily responsible for it. However, the large majority saw the school as a complement to the education they, themselves, would give. Some added that since certain parents did not take responsibility for informing their children, the school had a duty to act. Some felt that the information program would be given too late in the students' school life; they wished that it would start in the early school years and be given gradually until the end of secondary school.

Many parents said that they could not provide their children with basic scientific facts about family planning and were satisfied that the schools would give these. As for the values to be transmitted in this area, some parents said that



this was their exclusive domain; the school had nothing to do with it and should be restricted to giving factual information. Others objected strenuously to this, saying it would be dangerous for the school to restrict itself, since this would lead to dehumanization of sexuality.

In a survey of some 30 parents regarding the knowledge they passed on to their children, only five parents said that they had told their children about female and male anatomy, sexual relations, the menstrual cycle, abortion, venereal disease, childbirth, masturbation, contraceptive methods and circumcision. The other parents had all given information on male and female anatomy, with fewer and fewer parents having given information on the other subjects.

As for the departments' information program, a large number judged it opportune and valuable in the absence of any other sex education program; others asked that it be rounded out with courses on the psychological and social aspects. Parents saw the role of the nurse as a necessary one and did not reject the social worker, although they did not appear to see any specific role for this person. The role of the social worker, however did strike them as sufficiently reassuring and responsible that they could make no objection to his or her involvement.

Another significant point was that parents were in agreement in recognizing that students about to enter the labour

market were priority groups to reach with this program. There was no doubt in anyone's mind that the adult world does not provide adequate family planning information and counselling services.

d. Student Reaction

In our region in 1974-75 program staff almost exclusively concentrated on increasing awareness in the adult population. Students were the "poor relations" at this point in our action; in 1975-76 they were to become the direct beneficiaries of it.

The family planning information program per se was not offered to any student in the region but meetings were held with groups of 12-to-15 students on various themes including factual information and the psychological aspects of boy-girl relationships. These meetings proceeded as follows: introduction of the theme of the meeting, the presentation itself, questions and discussion, and distribution of written material.

This experiment indicated that it meets a real need, since all students have other opportunities to discuss questions relating to sex and family planning openly and positively. There is also a need to establish a definite atmosphere of confidence, so students can freely express their concerns and ask questions. The fear of appearing ridiculous because of ignorance is a very strong one for some.

However, some students went on to discuss subjects dealt

with at the meetings at home with their parents, to their mutual satisfaction.

When student feedback on these meetings was collected, a great deal of satisfaction with the atmosphere and themes was expressed. Students also said the meetings increased their sense of responsibility.

After the meetings there were virtually no requests for individual counselling. This fact supports the widespread opinion that teen-agers rarely seek such counselling.

### Conclusion

The experience acquired in implementing the High School Information Program in the region served by this Social Service Centre confirms certain conclusions that the author has already reached from other experience in the field:

- a. There is a need for increasing awareness. Family planning services, whether designed to provide information or counselling, cannot be implemented without first increasing the sensitivity both of those offering the services and those receiving them.
- b. There is a need to involve the community, i.e., to act in concert with it in a multidisciplinary framework, applying a program to meet community needs. The High-school Information Program had the weakness of being drawn up for the province as a whole.
- c. There is a lack of information. With all the publicity there

is on family planning, contraception and sexuality, we are all too easily led to believe that there are no secrets left about these subjects. However, anyone even slightly involved in work in these areas realizes that ignorance runs rampant and that teen-agers do not escape this situation.

d. There is a role for social work in this field. Social workers have been successful in creating an awareness of this program; some have provided information, bringing the psychosocial element into a field that can all too easily become totally medical. Their knowledge of the helping relationship make them particularly skilled in individual counselling or work with small groups.

In conclusion, the action undertaken in the High School Information Program has been highly positive. On one hand the nurses and social workers will continue their efforts; on the other, the Quebec Department of Education will enable school boards wishing to provide sex education to do so.

## A FAMILY LIFE EDUCATION PROGRAM WITHIN THE SCHOOL SETTING

Freda Rashkovan, M.A., A.A.S.E.C.

This article will attempt to describe the development and implementation of a family life education program created by the Family Life Education Department of the Jewish Family Services - Social Service Center in Montreal, for the school setting.

In the late 1960s Jewish Family Services in Montreal, like similar family agencies (the Mental Hygiene Institute and Catholic Family Services) became increasingly concerned with what they considered were growing symptoms of individual and family instability. To that point in time the agency had specialized in crisis intervention and clinical services exclusively. For the first time, consideration was given to alternative services which would involve education for skills in living generally in any form of family (nuclear, extended, single parent, etc.).

### Historical Perspective

A form of training seems to be available for most roles one assumes in life; the outstanding exception is the lack of training for the familial roles into which one is thrust. The North American life style, developed over the past decade and a half, reflects a growing struggle with the attempt to fulfil one's roles

in a way that is both satisfying and effective. Most models were based on traditional roles and the roles had begun to modify. It is difficult for a person to think in terms of training for something which he or she had assumed would come about naturally.

For two years Jewish Family Services investigated the work of other agencies that had already developed educational or non-clinical programs aimed at counteracting some of the problems occurring in families. A staff person was sent to receive additional training in this area. A few pilot projects with groups focusing on marital relations and child rearing were formed. By 1969 Jewish Family Services officially launched its new service, family life education. A full-time supervisory staff person was hired to develop a program, train personnel and assume the administrative responsibilities of the department.

The first step for the newly formed department was to hire a core of potential family life educators. A two-year training program was developed. It consisted of a cognitive aspect dealing with human growth and development, group dynamics, interpersonal relationships, the sociology of the family, sexuality, and leadership skills. The affective aspect involved participation in sensitivity training to develop self-awareness and provide an opportunity for the leaders' own growth. The third aspect was an internship which provided the leaders with an

opportunity to test the new skills they acquired.

The first programs were designed for adult groups and included a variety of topics: marital relationships, child rearing, adoptive parents and Jewish identity. Although these programs were aimed at adults, it soon became clear that to prevent individual and family instability it was necessary to get to the children. The most obvious resource for working with children was the schools. As Jewish Family Services was a private agency under the umbrella of Allied Jewish Community Services, its mandate was to serve the Jewish Day Schools. This provided the agency with a potential population. The school program started with levels six and seven in the four branches of the United Talmud Torah, a Jewish Day School System in Montreal.

#### General Overview of the Present Program

By the 1975-76 season, the staff increased to two full-time supervisors, 16 family life educators (working on a per diem basis) and 13 family life educators in training. This staff provided leadership for approximately 125 groups covering the range of normative issues within the developmental stages: that is, school groups dealing with the topic "understanding ourselves" and adult groups concerned with such issues as "parenting," aging, and self-awareness. School groups comprise almost two-thirds of all groups.

Initially all groups were self-financing (fee) basis.

The agency budget then provided for the school program and only the adult groups were self-financed. Eight years after the creation of the Family Life Education Department, its program apparently had gained credibility. Parents of school children were no longer fearful of the kinds of things the family life educators might be telling their children. This was reflected in the lack of attendance at orientation or evaluation meetings prior to or after a program in the school. In the early years such meetings attracted many parents who had many questions. Although the seal of approval is welcome, it is also sad in terms of the fact that it makes it difficult to involve parents in a program concurrent with their children. The Department feels that parallel programming would produce optimum results.

#### Program Objectives

The general program was designed to help family members learn to do a better job in their relationships with each other. It is also directed at helping young people understand themselves in the light of preparing for their own future.

The purpose of the agency's program is generally stated as strengthening and enriching Jewish Family Life and preventing family breakdown. The emphasis is on improving interpersonal skills.<sup>1</sup>

Each program, be it within a school milieu or for the general community is group-oriented exclusively. Each group consists of 12-15 members and meets for eight consecutive weeks.



A school group meets for one hour and an adult group, two hours.

The goals of the total program focus on helping individuals to develop increased awareness, sensitivity, trust, self-confidence, spontaneity and intimacy. The school program encompasses the same general aims but is a more structured program and its objectives are based on the theory of curriculum as outlined by Hilda Taba in Curriculum Development: Theory and Practice; that is, to use educational objectives for both the cognitive and affective aspects of the program. The method of stating objectives in this way assists in evaluating the program as well.

The general aims and goals of the school are to assist the student to:

1. Develop emotional independence;
2. Develop a sexual identity;
3. Alleviate anxieties in relation to his or her stage of development and in his or her social interactions;
4. Develop skills in decision-making;
5. Build a value system.

The educational objectives are broken down into two categories, Academic Skills and Social Skills.

The Academic Skills objectives include:

1. Listening;
2. Comprehending material (vocabulary, process of puberty, emotions);
3. Presenting information orally and in written form;

4. Drawing conclusions;
5. Transferring knowledge to new situations.

The Social Skills objectives include:

1. Participating in a discussion;
2. Working in a group, sharing information;
3. Asking appropriate questions;
4. Role playing.

These specific educational objectives are based on the level of development of the level-six student and are culled from a variety of curricular material: Family Life and Sex Education, Esther D. Schulz and Sally R. Williams; Becoming a Person, Rev. Walter Imbierski, Editor; Family Living and Sex Education: Instructors Manual, Moreland and Latchford. They can be adapted to lower or higher grades, taking into account the stage of development and life experience of the students involved.

To meet the stated objectives, specific information about family life and sexuality is transmitted and discussion is used extensively to provide an opportunity for the student to express his feelings and attitudes about the new information he has received.

#### Program Description

The family life educators have a curriculum guide for each grade. These guides were developed within the department by staff. How-

ever, the curriculum for each grade in either elementary or secondary school is largely built on the issues that the students themselves raise. In this way, the program content is open to negotiation throughout the eight weeks.

Generally speaking, the grade six-to-grade nine programs deal with information about puberty and attitudes about sexuality, specifically self-image. The other area of major concern is peer group relationships and social interaction. In upper secondary school the sexuality issues move to contraception, abortion, venereal disease and decision-making about premarital intercourse. Parent/child relationships are common to all grades. Underlying concepts of all programs are decision-making, communication and value clarification.

For purposes of the program, each class is divided into smaller groups of about 12 students. They are for the most part mixed sexually. Provision is made within the programs for both the males and females to meet separately if they feel the need. Teachers may or may not be involved directly in the program. An attempt is made to have an orientation program with the teachers of the students so that the teachers can carry on after the specific program is over. Depending on the school or the teachers, teachers may become co-leaders to groups. Whatever model is used, provision for exchange of information and feedback between teacher and educator is attempted and in large measure happens.

The program is seen as being a catalyst in that it offers the students an opportunity to have this kind of a discussion with an adult. An attempt is then made to transfer this experience to other adults such as parents, teachers, guidance counsellors or social workers.

Jewish Family Services also serves most of the schools in which there is a family life education program with a school social work program. One of the functions of the social work program is to act as a back up for the family life education program. The FLE program has a case-finding aspect to it: many times, students are found to need individual kinds of intervention. In these instances referrals are made to the school social worker which can be followed through with the student, or the family may be brought in. This can be considered primary prevention in that the case is discovered at an early stage, possibly averting a crisis. One sobering note is that if the family life education program starts only in later grades, rarely is really new information discovered about a student who is having trouble.

#### Evaluation

Several research projects have been done on this family life education program. It has been found that the students do acquire a significant amount of information and that they do improve their self-image.<sup>2</sup> Verbal feedback from students, parents and teachers suggest that behaviourally, interactions between students are more

sensitive (less scapegoating, fewer put-downs, etc.) and that communication is more open.

The growing credibility of the department is reflected by increasing demands for the program. More and more, it is being found that the use of an agent from outside the school system is effective in this kind of program. Students seem to be less inhibited about asking questions that they would hesitate to ask their teachers, even teachers with whom they have good relationships. Another factor is that family life educators do not sit in a teachers' room where there is a free exchange of information about students.

One problem being encountered, however, is resistance by some teachers. Many of them feel that the family life educator is usurping their role. Another factor is that parents are not as involved as would be desired for purposes mentioned earlier. While there are ever-increasing resources of information, program and curricular material, there is still a shortage of research data or effective evaluative material. Financing is an other source of problems. It seems that there will never be sufficient funds to provide a comprehensive coverage of a school. As a result, priorities have to be made which lead into the controversy of whether the educator starts early or catches students before they leave. There are really good arguments for and against both approaches.

In conclusion, there is no panacea to all problems confronting an individual or family. However, the family life education program has demonstrated that some issues can be approached through this method. It is hoped that further empirical study and the constant efforts at improvement will make the program even more effective in the years to come.

# FOOTNOTES

<sup>1</sup>Freda Rashkovan, "Family Life Education," paper presented at the National Conference of Jewish Communal Services, Philadelphia, 1973.

<sup>2</sup>Freda Rashkovan, "An Evaluation of a Family Life Education Program" (Masters Thesis, Sir George Williams University, Montreal, March 1974.)

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NEW DIRECTIONS IN SEX EDUCATION  
FOR  
CHILDREN IN FOSTER CARE  
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Do the responsibilities that a child welfare agency has for the total care and development of a child who is a permanent ward include a responsibility in the area of sex education? An increasing number of agencies are asking themselves this question and concluding that in their role in loco parentis the answer can only be yes.

This paper discusses new directions in sex education policy and program development in Canadian voluntary child welfare agencies, and examines some of the problems associated with educating the foster child for sexuality. Information about agency programs has been drawn from correspondence with child welfare agencies and, in a number of instances, from the author's experiences in providing consultation regarding policy formulation or in acting as a resource person in staff development programs in these agencies.

Attention is focused on efforts to meet the needs of permanent wards, since the child welfare agency has complete legal responsibility for this group of children. Although child protection legislation differs slightly from province to province,

in most instances when a child, through court action, becomes a permanent ward of a province all the rights and responsibilities formerly held by the parents are transferred to the provincial child welfare authority, or, in some instances, to a children's aid society or other recognized voluntary agency operating under the supervision of the provincial authority.

The sex education needs of the temporary ward may be just as great as that of the permanent ward but, depending on individual circumstances, the agency would probably involve the natural parents in planning for this and other aspects of the child's care. Temporary wardship is used in situations that offer some hope that the child can be returned to the home of his or her natural parents. If, after a reasonable length of time, the natural parents still cannot make an adequate plan for the care of the child, the child is likely to become a permanent ward. Some provinces also offer non-ward care, in which case the parents retain custody and continue to play an important role in rearing the child.

While the child is in the custody of the child welfare authority he or she may be placed in the care of foster parents whose home has been approved for this purpose, or perhaps in a group care facility. The child welfare authority retains responsibility for the quality of care the child receives.

The total care and development of the child is usually

interpreted to include not only the provision of food, shelter, clothing, medical and dental care and education, but also those intangible elements of parenting which have the objective of enabling the child to become an emotionally mature, responsible adult, with a capacity to form healthy relationships with other human beings.<sup>1</sup>

The ages of children at the time they come into permanent care range from infancy to adolescence. Although some, particularly infants, are subsequently placed for adoption, others remain in the care of the child welfare authority until they reach the age of majority. In some provinces, under certain circumstances, the care of an individual child may be continued beyond the age of majority. At any one time there are likely to be as many as 95,000 children in the care of child welfare authorities throughout the country, some of whom will be infants awaiting adoption.

Most child welfare agencies have always acknowledged some responsibility for sex education. Information regarding menstruation, nocturnal emissions, boy-girl relationships and reproduction has usually been handled on an individual basis by the child's foster parents, often with the guidance of the social worker, or by the social worker discussing the matter directly with the child. However, in the past the amount of information provided, its accuracy and timeliness and the free-

dom with which sexual material was discussed varied according to the knowledge, values and comfort of the individual foster parent, child care worker, or social worker, or, in some instances, according to the prevailing philosophy of the particular agency. Thus masturbation," in the case of adolescents, might have been regarded as being either a problem or a normal function, depending on the attitudes of those responsible for their care. Until recently, information about birth control or access to contraceptives was rarely provided to adolescent foster children.

Several inter-related developments have led many child welfare agencies to re-examine the dimensions of their responsibilities regarding sex education. Agency board members, administrators, social workers, foster parents, child care workers and foster children are no less affected than is the general public by the tremendous shifts in attitudes associated with the current sexual revolution.

The 1969 amendment to the Criminal Code legalizing the sale of contraceptives and the dissemination of birth control information, the entry of the federal government into the family planning field in 1970, and the women's movement have also played a part in influencing changes in agency policies and practices.

Largely as a result of the work of sex educators and researchers, a new understanding of human sexuality has emerged. Sexuality has come to be regarded as being far more than coitus

or reproduction; it is a vital dimension of the total personality, a part of one's identity.<sup>2</sup> It includes feelings towards oneself as a sexual human being and feelings towards others as sexual human beings. The development of a healthy sexuality is now considered by many to be essential to the development of a healthy personality. This new philosophy has not escaped the notice of the child welfare field.

While the sexual revolution has had an impact on all age groups, including the aged, its most profound influence has been on youth. Adolescents and young adults, generally speaking, have a much more open approach to sex. Whether or not they themselves are sexually active, they tend to be much more accepting of such behaviour among their peers than were earlier generations of young people. There is no reason to suppose that adolescents in foster care differ from the general population of adolescents in this respect.

Along with greater sexual freedom has come an increase in the incidence of venereal disease among youth. As well, the number of illegitimate adolescent pregnancies, as reflected by both the abortion rate and the number of illegitimate births among teen-agers, has not decreased in spite of relatively easier access to contraceptives. While no data is available that would permit a comparison between the incidence of venereal disease or illegitimate pregnancy among adolescents living with their natural

parents and that of adolescents in foster care, some child welfare workers suggest that an adolescent girl who has experienced an emotional loss or deprivation may be more vulnerable to illegitimate pregnancy.

The new concept of sexuality as a healthy entity, or, in some instances, concern about venereal disease and illegitimate pregnancies, has served to focus renewed public attention on the question of sex education in the school system, a development supported by most child welfare agencies. Some schools have developed good programs, but this is certainly not the case throughout the country. Questions regarding a definition of sex education, its objectives and desirable content, and its place in the school curriculum are still unresolved issues in many communities.

But even with the most comprehensive school sex education program--one that extends from kindergarden through high school--parents will continue to play a vital role in the development of a healthy sexuality in their child. In the first place, attitude formation begins long before the child starts school. Moreover, parental attitudes are communicated by non-verbal as well as verbal means to the infant as well as to the adolescent.

It is generally agreed that adolescents, including those who are foster children, are influenced to varying degrees by the value systems and behaviour of their peers. However, few people

would suggest that parental responsibility in this area ends when the child reaches adolescence.

In discussing the differences between the role of the parent and that of the sex educator, the Sex Information and Education Council of the United States (SIECUS) recognizes that:

... parents play a very basic role in shaping their children's value systems in all areas, including that of sex conduct. The parents' role is fundamentally different from the educators' in that parents transmit values, both consciously and unconsciously, in the complex behaviour and feelings of day-to-day life in the family. Parents bring all of their personal life experiences to the bearing and rearing of children. They transmit values mostly in terms of these experiences and in terms of the situations confronting the family. Little of this transmission is cool, rational, objective, scientific. A parent is too emotionally involved with his child to take a calm, detached attitude toward the child's values and behaviour or to be an objective educator. However, he does have responsibility and an opportunity of inculcating the moral attitudes that will form the basic ethical framework for his child. No one can replace him in this task.<sup>3</sup>

SIECUS goes on to emphasize that the sex educator is not a parent but a teacher, whose role in a democratic-pluralistic society is not to indoctrinate students, but to teach them how to think.<sup>4</sup> It is the responsibility of the teacher to provide reliable data with which to help students reach their own decisions in as objective and unbiased manner as possible.

Although there is no Canadian data on the question of where children learn about sex, it is believed that in a great many instances they continue to receive most of their information,

much of it of doubtful accuracy, from their friends. Diane Sacks and Doris E. Guyatt, in a study of 175 girls, ages 14-19, using the Scarborough (Ontario) Family Planning Clinic found that the mother of the girl was listed as the major source of information about menstruation, but in most cases the mother had discussed only menstruation.<sup>5</sup> Seventy per cent of the girls said that they had learned about sex from their girl friends or from their high-school family-life education course. It is possible that foster children have less need to depend on friends for sex information than do children living with their natural parents, but there is no documentary evidence of this.

If one accepts the distinctions between the roles of the parents and the sex educator suggested by SIECUS, the child welfare agency probably falls somewhere in between. The social worker presumably is not emotionally involved with the child and presumably does not attempt to impose her or his own values on the child. The foster parent is more likely to be emotionally involved and to be influenced by personal values in caring for the child. This is not to suggest that such a situation is necessarily problematic. Indeed, if all agency persons in contact with the child were to take on an objective, detached stance, there would be no one to fill the parental role which SIECUS regards as essential. The solution appears to be in having enlightened social workers and foster parents.



To prepare any child to meet the sexual dilemmas of present-day society is no easy task; to prepare a foster child can be even more difficult. With the possible exception of very young infants, children do not come into the permanent care of a child welfare agency with a blank slate. Some will have experienced some degree of neglect, abuse or rejection by their natural parents. Others may feel abandoned even though placement was the most responsible decision the parents could make in their particular circumstances. Some will have developed a poor image of adults and of family relationships. They will have been influenced, either positively or negatively, by their natural parents' attitudes in many areas including sexuality. In instances where living with the natural parents has been particularly damaging, the agency's most important task may be to provide a corrective emotional experience in all aspects of family life.

An additional complication in educating the foster child for sexuality results from the fact that the child may be placed in more than one home during the period he or she is in the care of the agency, with the possibility that the value systems of the two or more sets of foster parents may be quite different.

#### Agency Policies

As child welfare agencies review their policies and practices in relation to sex education, some conclude that since the agency is

already responsible for the total care and development of permanent wards, it is unnecessary to formulate a written policy dealing with this subject. They believe that their responsibility for this aspect of child development is already implicit in existing policies. Others have included a specific mention of sex education in policy statements on family planning and abortion. An example is the policy statement of the Family and Children's Services of London and Middlesex, Ontario, which contains the following paragraph:

In its role 'In Loco Parentis', the agency accepts the responsibility for education of its children. This includes the area of formation of attitudes towards family life; the understanding of self; respect for others; and the responsibilities as well as the gratifications associated with sexual relationships. The agency's responsibility is implemented through substitute parents and staff members.<sup>6</sup>

That agency's policy statement also acknowledges the influence which the child's earlier experiences may have had on his or her current values as follows:

The foster parent and the social worker must recognize that many of our children have already formed value systems based on their own life experiences. The child's values and actions in the sexual area may not always be compatible with those of the worker or foster parent, but should be viewed in relation to the child's background.<sup>7</sup>

#### Staff Development

Once an agency arrives at a policy position regarding sex education, the next question concerns how the policy is to be

implemented. Social workers, child care staff and foster parents need an opportunity to fill in gaps in their knowledge about sexuality, to examine their attitudes and values and to become comfortable with their own sexuality and that of others.

It soon becomes apparent that there is no way of becoming instantly comfortable with a subject which has been taboo during most of one's life. Some agencies have sought help from outside resources such as nurses, physicians, family planning groups, SERENA or the Family Planning Division of the Department of National Health and Welfare. The federal government provides free publications, consultation and other forms of assistance to agencies in the development of programs related to family planning and sex education.

In some instances agencies have sent interested staff members to special seminars on sexuality, with the expectation that on their return they would act as resource persons in a staff development program.

#### Foster Parents

In many agencies the knowledge and attitudes of foster parents are also receiving attention. Orientation meetings for couples who have expressed an interest in becoming foster parents are increasingly including discussion of sexual values. As well, the home study process provides an opportunity for the agency to assess the attitudes of the couple and to identify potential

problem areas. Agencies that sponsor on-going educational programs for foster parents, e.g., London,<sup>8</sup> Kapuskasing,<sup>9</sup> and Cornwall,<sup>10</sup> are increasingly including content on sexuality. In 1973 the Children's Aid Society of Bruce County (Ontario) expected that sexuality would be one of the topics considered by the small, informal discussion groups the agency was organizing for foster parents.<sup>11</sup> In Kitchener the Foster Parents' Association took the initiative themselves by inviting members of the medical and nursing professions to conduct a series of discussions relating to sexuality.<sup>12</sup> The meetings involved both foster parents and foster children.

#### The Foster Child

For the younger foster child, information tends to be provided on an individual basis. The foster parent and the social worker are encouraged not only to respond to the child's questions as they are asked, but also to introduce age-appropriate information on suitable occasions, in a relaxed manner.

Several agencies are experimenting with programs involving groups of pre-teen and adolescent children, in some instances with foster parents as part of the group. Family and Children's Services of Norfolk County report that social workers have arranged meetings involving 14- and 15-year-old girls and boys and their foster parents.<sup>13</sup> Factual information on physical changes of adolescence, contraception and venereal disease is

included, as well as discussion of dating, parental attitudes, "moral decisions" and feelings. Films, questionnaires, literature and role plays are used as discussion aids. The agency is also planning sessions for older teen-agers, without the presence of foster parents. These sessions will include more detail about family planning, early marriage and social attitudes.

The former Catholic Family and Children's Service of Vancouver organized communication groups for house parents and children living in the agency's group homes.<sup>14</sup> Sexuality is one of the subjects dealt with. The Children's Aid Society and Family Counselling Service of Guelph (Ontario) used a volunteer from the local planned parenthood group to lead a discussion on sexual responsibility and a demonstration of contraceptive devices for the agency's group home for girls.<sup>15</sup> The group home worker is currently exploring ways of regularly incorporating discussion of sex into a program for all of the agency's group homes. This would involve children 10 years of age and older.

The Children's Aid Society of Bruce County (Ontario) has used a foster mother as a discussion leader for groups of foster children.<sup>16</sup> Many aspects of boy-girl and man-woman relationships have been dealt with.

In London, the Children's Aid Society has group sessions for adolescents who are experiencing problems in the area of sexuality.<sup>17</sup> The approach has been one of responding to the needs

which the group itself has identified. The agency feels that its main role is to supplement and complement the family life education courses provided by the schools. The agency-sponsored small discussion groups offer an opportunity for the adolescents to discuss their own feelings and attitudes about material introduced at school.

The Hamilton-Wentworth Children's Aid Society has attempted a sex education program for a group of intellectually limited pre-teen girls.<sup>18</sup> A very simple approach was used, one focus being on menstruation and personal hygiene, with the use of films and discussion periods.

One of the most interesting approaches to learning about sexuality is that of the former Children's Aid Society of Vancouver.<sup>1</sup> In January 1973 a co-ordinator of human sexuality programs was appointed to be responsible for co-ordinating all of the agency's activities in this area. It was soon discovered that groups that combine non-professional staff, professional staff and foster parents provided a much more dynamic group than did an earlier attempt to have a single workshop for social workers. Each group participates in a total of six weekly sessions. The content is largely drawn from "About Your Sexuality", an audio visual program developed by the Beacon Press of Boston. Discussion groups are also arranged for children age 13-18 years. In these groups a male social worker acts as co-leader with the female co-ordinator.

In group home settings the house parents are included. It has been found that children pursue the discussion with house parents after the session is over if the house parents have been present and have participated in the discussion. The main objective of the sessions for adults, as well as those of children, apart from making basic information available, has been to create an atmosphere of comfort in which participants can explore their own feelings and attitudes and make responsible decisions.

Obviously an educational program for foster children must take into account the presence in the home of the foster parents' own children. Increasingly, foster parents are choosing to have their children participate in agency activities including sex education programs.

#### Related Activities

A number of child welfare agencies are involved in related activities with client groups other than foster children. In some instances contraceptive counselling provided to unmarried mothers includes a sex education dimension. Increasingly questions related to sexuality or family planning are discussed with the agency's adult clients.

Several agencies participate in programs for the wider community. Social workers at the former Vancouver Catholic Family and Children's Service share with the Catholic Information Centre of the Archdiocese in presenting a pre-marital course "Marriage in

Contemporary Society.<sup>20</sup> That agency also has a high school presentation program which has enabled thousands of Vancouver area high school students age 15-18, to take part in discussions regarding sexual behaviour, values, etc. This program began in the private Catholic schools but is now frequently requested by public high schools. Role plays and a film on single parent-hood entitled, "To Love and to Care For" which was produced by the agency, serve as discussion aids in many of the presentations.

The above examples of agency programs illustrate some of the approaches currently being tested by child welfare agencies as they search for more effective ways of meeting their responsibilities in the area of sex education. Attempts are also being made to meet the needs of mentally retarded, physically handicapped and emotionally disturbed foster children.

#### Observations

In commenting on their experience to date, a number of agencies have said that educational activities for staff and foster parents should be on-going. A single, one-day workshop might serve mainly as a consciousness raising activity. But changes in attitudes and feelings (such as a person's being comfortable with sexuality) are more likely to occur when there are repeated opportunities for free discussion and examination of all aspects of sexuality.

There is a marked preference among agencies for the use



of small groups that permit maximum verbalization. All stress the importance of providing a relaxed, supportive atmosphere for group meetings, whether they are for children or adults. Audio-visual material, role plays and literature are considered indispensable learning aids. Several agencies regard sex education as being only a component of family life education and place considerable emphasis on family relationships.

Since most of the activity described in this article was initiated only two or three years previously, agencies had not formally evaluated the effectiveness of their programs. Considerable experimentation seems to be necessary. Not all social workers, child care workers and foster parents in any one agency immediately embrace a change in agency philosophy or policy, or the means by which the new philosophy is put into practice. For that matter, not all agency boards are prepared to endorse a change in philosophy. But agencies that have ventured into the field of education for sexuality believe that they are on the right track. Mr. A. Petersen, Director of Children's Services, of the Family and Children's Services of London and Middlesex, in commenting on that agency's experience to date says:

It is obvious to us all that there is a need for this kind of service to our clientele of children and adults and, whereas the value of such may not be easily defined scientifically or statistically, we have received encouragement and expression of appreciation<sup>21</sup> from individuals and groups with whom we are involved.

As schools develop comprehensive sex education programs, the role of the child welfare agency with regard to its foster children will likely become that of supplementing the school program, with particular emphasis on early childhood, and on helping children develop their own value systems. The experience gained by child welfare agencies in assisting foster parents could conceivably be useful in family life education programs for natural parents, particularly programs operated by social agencies.

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- <sup>3</sup>Ibid., pp. 157.
- <sup>4</sup>Ibid., pp. 158.
- <sup>5</sup>Diane Sacks, and Doris E. Guyatt, The Adolescent Girl's Need for Birth Control (unpublished report of study conducted at Scarborough Family Planning Clinic, Toronto, Ontario, 1972), p. 11.
- <sup>6</sup>Letter from A. Petersen, Director, Children's Services Department, Family and Children's Services of London and Middlesex, London, Ontario, December 17, 1973.
- <sup>7</sup>Ibid.
- <sup>8</sup>Petersen.
- <sup>9</sup>Letter from Jacques Martel for Keith Willcock, Local Director, North Cochrane District Family Services, Kapuskasing, Ontario, December 20, 1973.
- <sup>10</sup>Letter from Thomas J. O'Brien, Executive Director, The Children's Aid Society of the United Counties of Stormont, Dundas and Glengarry, Cornwall, Ontario. January 7, 1974.
- <sup>11</sup>Letter from Britt-Inger James, Executive Director, The Children's Aid Society of Bruce Inc., Walkerton, Ontario, December 21, 1973.
- <sup>12</sup>Letter from W.A. Hunsberger, Executive Director, Children's Aid Society of the Municipality of Waterloo, Kitchener, Ontario, January 3, 1974.
- <sup>13</sup>Letter from A.M. de Swaaf, Executive Director, Family and Children's Services of Norfolk County, Simcoe, Ontario, December 13, 1973.
- <sup>14</sup>Letter from F.J. McDaniel, Executive Director, Catholic Family and Children's Service, Vancouver, B.C., December 27, 1973, now part of Vancouver Resource Board.

<sup>15</sup>Letter from F.C. Promoli, Executive Director,  
Children's Aid and Family Counselling Service, Guelph, Ontario,  
January 24, 1974.

<sup>16</sup>Britt-Inger James.

<sup>17</sup>Petersen.

<sup>18</sup>Letter from M.R. Hollinger, Executive Assistant,  
Children's Aid Society of Hamilton-Wentworth, Hamilton, Ontario,  
January 17, 1974.

<sup>19</sup>Letter from Amy F. Napier-Hemy, Coordinator of  
Sexuality Programs, Children's Aid Society, Vancouver B.C., December  
12, 1973, now part of Vancouver Resource Board.

<sup>20</sup>McDaniel.

<sup>21</sup>Petersen.

THE IMPACT OF A SEXUALITY PROGRAM ON PARTICIPANTS,  
PROVIDERS, AND AGENCY STAFF

John A. Vedell, Th.M., Dip.M.H.C.

Picture a nursery school setting early in the evening. The scene includes several play areas: odd-shaped wood blocks in one corner; cardboard bricks sufficient in quantity and size to build a house, together with a family of hand puppets in another; a sandbox. As well, Mr. & Mrs. Hooded Rat live in a very special area. Mrs. Rat is pregnant and soon due to deliver.

Enter eight three-and four-year-olds who scatter to the play areas. Their parents follow a little way behind them. The parents' participation as they move from play area is self-conscious, but they gradually discard their inhibitions--unlike Mr. and Mrs. Rat whose most frequent visitors are the children.

"How are you tonight, Mrs. Rat?" they ask. "You still have your babies inside?" "I wonder when your babies will be born. Maybe tonight?"

Now it is time for a brief animated film which depicts the reproductive system in animals and humans. Half way through the film several children point to the screen and shout, "Penis, penis!" The parents react to this outburst with none of the embarrassed giggles or hushes that might have been expected. Instead, they appear quite bemused and one or two give shyly proud smiles. In contrast, a few months previously many of these

parents and their children used words such as "peepee," "dickydee," and "worm."

This vignette is based on a session of a demonstration project, "Parents and Children in Sexuality Seminars" (PACIS),<sup>1</sup> sponsored by Family Services of Hamilton-Wentworth and supported by a family planning grant from the Department of National Health and Welfare.

#### Genesis of Pacis

PACIS was designed in 1973 in response to a need for sexual education expressed over a period of several years by several users of the agency's neighbourhood-based family development program (a program for preschool children and their parents, primarily mothers). The program users expressed a need not only for knowledge but also for opportunities to discuss their feelings about sexuality in children and adults to sort out what is appropriate sexual behaviour in children and adults and to come to terms with how, as parents, to talk with children about sex. In summary, the project set out to focus on knowledge, attitude and behaviour in regard to human sexuality and to measure any change in parent participants in regard to those categories.

#### Theoretical and Practical Considerations

As expected, a search of the literature revealed general agreement as to the crucial nature of the first five years of

life as the time when a person forms basic attitudes towards sexuality. The literature also supported our assumption that the young child's major models are its parents or parent surrogates. It was assumed that parents' behaviour around preschool children is important, as any change in parental modelling would produce optimum impact on their children in their formative years. We were also interested in testing whether parents would change more if the program involved their children. The literature revealed no major examples of sex education programs that focus concurrently on parents and their preschool children in parallel, conjointly as a family, or within a mixed group of parents and their preschool children.

A possible objection to including preschool children in a sex education program for parents is the risk that pre-logical concept formation might lead to erroneous and even damaging ideation (e.g. babies grow in the "stomach," therefore eating is dangerous). However, the program developers felt that, in the light of the many positive results of including young children in family therapy, destructive or harmful effects on preschoolers in a sexuality-oriented group could be avoided. Focus in such sessions on play and visuals rather than adult discussion was considered another safeguard.

Other barriers to the involvement of preschoolers in

a sexuality program are largely pragmatic in nature. Opportunities to involve preschool children in such a program are relatively rare, largely limited to preschool settings such as nursery school and day care. Even where a preschool facility or program exists there are strong social sanctions against formal sex education for young children.

We were fortunate in having both a nursery school setting available and parents who (not without some reluctance) agreed to including their preschool children.

#### Project Design

The PACIS program called for two series of eight group sessions (a total of 16 sessions) to be held during the fall of 1974 and early spring of 1975. Two matched groups of parents were selected from a pool of applicants. One of the groups was to include the preschool children of the participant parents on four separate occasions during the second series. The participants were to be either on public assistance or classed as working poor.

The final design for PACIS called for a control group of up to 50 parents of preschool children in addition to the two program groups which each consisted of 16 parents of preschool children. To lessen control-parent disappointment at not being included in the program groups, we opted for a modified control group (control parents were given literature



and involved in "before, during and after" questionnaire sessions at which films were shown). In addition they were promised that, should the project prove successful and further PACIS programs be integrated into agency programming in the future, they would be given priority for inclusion. Evaluation instruments were selected<sup>2</sup> by the research consultant and plans made to test all three groups prior to the group sessions, after the first eight group series, after the second eight group series, and five months after the program.

#### Program Leadership and Training

Two professional social workers were each teamed with a trained indigenous worker. The indigenous workers were drawn from settings similar to those of the program participants. Though the project called for a group-centred approach as to choice and timing of topics, it was agreed that the group leaders would need to know about the psycho-physical-social aspects of human sexuality, family planning, conception control, and the physiology of orgasm so as to be credible in the eyes of the participants and to be able to make accurate and helpful contributions to the group. Also it was anticipated that the leaders' attitudes (and perhaps behaviour) in regard to human sexuality might benefit from exposure to desensitization processes prior to beginning the program.

The four group leaders together with the project director, associate project director, and program assistant

met for seven two-hour training sessions prior to the PACIS program. Project consultants provided leadership and guidance for these sessions. Various guest consultants were brought in on a timely basis.

Training sessions focused on the following themes: sexuality-definitions, relationships, psychosexual development and "normality"; heterosexuality, anatomy, physiology; contraception, reproduction, masturbation, homosexuality; sexual problems related to socialization; teaching children about human sexuality; sex education/curriculum planning: and group skills.

Participants in these sessions moved through normative group stages and developed strong cohesiveness. They all agreed that their own knowledge, attitudes and behaviour were affected positively by the training experience, and that they had experienced phenomena similar to those that were later experienced by their own program group members.

Ongoing group-work consultation sessions were contracted to provide the group leaders continued support throughout the program.

The inevitable question as to how well non-medical personnel can respond to questions centred on physical and medical aspects of sexuality may be asked. Our experience was that, with adequate preparation and consultative resources, the professional and indigenous workers were able for the most part to give adequate and accurate information on normative

physiological and anatomical aspects of sexuality. When unsure of themselves they were careful to declare uncertainty to their groups and promised to bring answers back to the next session after appropriate consultation. Participants who inquired about personal symptoms or pathology were asked in a supportive manner to consult their doctor. It has been observed that, even where a PACIS leader might be a medical doctor, this would be the best way to handle such enquiries, on the grounds that the PACIS group contract does not provide for such extra medical consultation.

#### Impact of Pacis on Participants

Subjective evaluations by group leaders, observers of group sessions and various participants were that participants who persevered throughout the program (and to some extent, participants who took part in only part of it) made noticeable gains in knowledge about human sexuality, conception control and family planning. They also observed that the participants demonstrated considerable change of attitude in a few cases, and some degree of change of attitude in most cases. This was especially noticeable in one of the groups when the Transactional Analysis paradigm of Parent, Adult and Child facilitated participants' ability to examine with lessened threat many of their unexamined assumptions and values about human sexuality, especially with regard to such highly charged areas as masturbation, homosexuality,

and abortion.

It was more difficult to assess behavioural changes among participants. Although participants claimed there were behaviour changes at home by both children and parents, there was no way for the group leaders to confirm this. However, in the group that met four times with children it was observed that there were some inconsistencies between parents' reported behaviour and behaviour actually observed when the parents and their children interacted during the parent-child sessions.

One spin-off benefit of the sessions was that some participants reported enhanced communication and relationships within the family involving many areas of concern, including sexuality.

Somewhat to our surprise, some participants whose spouses were not in the PACIS group reported improved marital relationships in terms of general communication and sexual relationships. It would be inaccurate to give the impression of a "total success" as there were some who dropped out (nine of the original 33 participants). Reality factors accounted for some but others apparently could not tolerate the anxiety exacerbated by the subject matter. In some cases only minimal gains towards open communication between participant marriage partners were observed, but it is to be remembered that these were not therapy groups. The group leaders' over-all subjective impression was

that participants who persevered displayed in varying degrees a number of gains in the 16 weeks of their participation. These subjective evaluations are supported by the research analyses to date.

Here are certain over-all conclusions<sup>3</sup> and a few salient highlights garnered from an ancillary post-program questionnaire:<sup>4</sup>

1. The more that people were in favour of providing sex education for children, the more they favoured birth control, the more they held relatively liberal family attitudes, and the more they knew about sex and sexuality.
2. The program resulted in relative gains in the participants' knowledge and attitudes about facets of human sexuality and the family.
3. The changes occurred after the first eight weeks, with little change thereafter.
4. The participant groups were indistinguishable, which suggests that the inclusion of children in group sessions did not affect their parents' change, although the children themselves may have benefited (not tested).

In addition to the statistical analysis of the research instruments, supplementary questionnaires were answered by 20 of the 29 remaining participants.

General. "Should we continue PACIS for other people? Is it worthwhile?" received 100 per cent affirmative response. Similarly, "Did you personally benefit?" received unanimous agreement.

Knowledge. Ninety per cent believed they had gained some or a lot of knowledge, the facets most highly cited being orgasm and climax, the human body and children's questions about sex, masturbation, birth control, homosexuality, parent-child sexual feelings, sexual relationships, and birth.

Attitude. Seventy-five per cent felt "a lot more comfortable now regarding human sexuality," and 20 per cent "a little more comfortable." The most significant facets were masturbation, children's questions about sex, children's sexual behaviour and feelings, homosexuality, orgasm-climax, intercourse and abortion.

Behavioural change. Eighty-five per cent agreed "I talk more freely with my children about sex," 80 per cent with "friends," 70 per cent with "my spouse," and 60 per cent with "other relatives." Sixty per cent endorsed "if my children masturbate, I am more accepting than I was." Forty-five per cent agreed that "adult sexual relations have improved."

On the basis of these findings we are encouraged to recommend the PACIS model. This intervention apparently facilitates gains for participants in sexual knowledge, attitudes

and behaviour. It is surprising, but a boon to efficiency, to note that little is to be gained by extending PACIS beyond an eight-week program (though our analysis cannot prove that extension of program beyond 16 sessions would not yield even greater change). It is disappointing to note that the involvement of children made no difference. Though the inclusion of children was a neutral factor in regard to parental change, our subjective opinion is that earlier and more consistent involvement might have made a difference. However, were this to be attempted another time it would be important to measure the benefits - if any - to the children.

#### Impact on Providers

As suggested in the description of the training process for PACIS leaders and staff, there was a strong impact on our knowledge, attitude, and behaviour. We all experienced gradual desensitization about sexual terminology and discussion. Our initial anxiety and feeling of threat had attenuated considerably by the end of the training period. We experienced openness to one another, and were able to share highly subjective concerns. This growth in comfort continued throughout the PACIS program sessions, especially in the group leaders. One worker felt the biggest change was in home life, including improved sexual relations. Another found that her children talked to her more

now about sex than ever before, and on a more "friend-to-friend" level. The indigenous workers found that they had been alienated by certain friends and relatives because of the workers' new attitudes and behaviour. The ongoing group-work consultation sessions were an excellent form in which to sort out personal feelings and ideas as a follow-through on the training sessions. All four of the group leaders went on to further training after PACIS, and are enthusiastic about conducting another PACIS group.

#### Impact on Agency Staff

It was not very long after PACIS leadership training commenced before it became apparent that agency staff not directly involved in the project changed from being rather indifferent to the PACIS program to being considerably interested and even envious. PACIS staff in their new-found comfort with sexuality and in their openness of expression at coffee breaks, team meetings or social gatherings elicited some degree of anxiety and even resentment among some of their colleagues. Gradually agency staff began to request PACIS literature and resource material for integration into their own practice. As time went on, various staff members expressed a desire to receive the kind of training the PACIS staff had enjoyed so that they might be more comfortable in their own feelings about sexuality and thus in their ability to handle rather than avoid sexual material in their counselling or other service activities with agency



clientele. The great emphasis in PACIS on parent-child and couple relationships led some unmarried staff persons to claim that there should be more focus on sexuality with regard to single people. Staff working with the aged, youth, separated parents, and single adults, expressed the desire to integrate PACIS training into staff development and apply it in their practice.

Following the PACIS programs the agency planned to offer similar PACIS groups to low-income users of its neighbourhood family growth services, and to middle - and upper-income people able to pay a fee for service.

#### Impact on Community

During the course of PACIS, a number of agencies in the community have shown interest -- some to the point of inviting PACIS staff to present PACIS to their staff and administration. A family agency in Rochester, New York, sent family-life educators to assess the applicability of PACIS to low-income, city core residents. Because the PACIS model is "portable," it is conceivable that with some preparation and training, PACIS could be used in a variety of community settings. A close liaison has been established with the McMaster University Sexuality Training program. Preliminary (and highly tentative) conversations have been held with a public health official as to how PACIS might tie in with existing or future family planning facilities

in the community. Several requests for inclusion in future training programs have been received from a variety of professionals.

#### Conclusion.

Participants' written comments at the completion of PACIS ranged from humorous ("the way the group leader described how to remove a shield") to the global ("the change in my children, my husband, father and everyone else around me"). Perhaps the following poignant submission best sums up what PACIS is all about:

The programme learnt me that I have a tongue in my mouth. I'm not shy anymore, I talk more to people and I'm not afraid to say what I think because I found out that other people are in the same boat as I was before the sessions started. My minister, friends and neighbours have said what a change had come over me ..... my husband is blind to a lot of facts and he sends the children to me to have sex questions answered. If he had taken the class he would enjoy the closeness myself and the children have when they know that I'll answer them and not be shoved aside until they get older type of thing.

To quote our research consultant, "other responses were similar, forcing us to conclude that changes occurred far and beyond those indicated by the structured assessments."

## FOOTNOTES

<sup>1</sup>Demonstration Project #4462-5-3, Family Planning Division, Department of National Health and Welfare.

<sup>2</sup>Ackerly, L.A., "The Information and Attitudes Regarding Child Development Possessed by Parents of Elementary School Children," University of Iowa Studies in Child Welfare, 1934, 10:115-167; Thurstone, L.L., Ed., The Measurement of Social Attitudes, Chicago: University of Chicago Press, 1931; Levinson, O.J. and Huffman, P.E., "Traditional Family Ideology and its Relation to Personality, Journal of Personality, 1955, 23:251-273; Nadler, E.B. and Morrow, W.R., "Authoritarian Attitudes Towards Women and Their Correlates," Journal of Social Psychology, 1959, 49:113-123; Lief, Harold I. and Reed, David M., Sexual Knowledge and Attitude Test (S.K.A.T.), Philadelphia: Department of Psychology, University of Pennsylvania, Second Edition 1972.

<sup>3</sup>At the time of writing, formal evaluation of the PACIS project, based on the research data, was still in process. Detailed statistical analysis and discussion will be included in the final report, to be available by mid-October, 1975. Copies may be ordered from Family Services of Hamilton-Wentworth, 22 Tisdale Street South, Hamilton, Ontario. L8N 2V9.

<sup>4</sup>The remainder of this section is based on a preliminary submission by Ian Begg, Research Consultant to PACIS.

CASEWORK WITH PERSONS SEEKING STERILIZATION:  
A STUDY OF ATTITUDES AND PRACTICES OF QUEBEC SOCIAL WORKERS

Marie Berlinguet, M.S.S. D.S.W.

Voluntary sterilization is a recent development in the field of birth control. Therefore it is not surprising that to date social work has not provided a specific practice guide for work relating to it. Practitioners who have to handle requests for psychosocial counselling in conjunction with applications for voluntary sterilization must themselves define their methodological approach, which they base on the theory of their profession and on the experience they have gained in the helping relationship. Admittedly, because of circumstances--since practice is often far ahead of theory--social caseworkers have become skilled in applying their general training to particular situations, as pointed out by Lydia Rapoport.<sup>1</sup>

However, if it is conceded that conceptualization makes it easier to pass on experience and helps to improve service, it is obviously essential to ascertain current practices--the elements that might be used in the development of theoretical models. It is from this point of view that in 1973-74 I undertook exploratory research among Quebec social workers who provided counselling in applications for voluntary sterilization.<sup>2</sup>

The Practice Among Quebec Social Workers--A Summary of the Research

The research was conducted among 18 practitioners at the university

level who were working in a francophone environment and who represented almost all of the caseworkers doing counselling on voluntary sterilization in Quebec. The population was divided among five hospital centres (eight practitioners) and six social service centres (10 practitioners). The institutions where the respondents worked are located in various regions of Quebec: Chicoutimi, Drummondville, Trois-Rivières, Montreal and Quebec City.

The interview-questionnaire method was used with the 18 practitioners and with one administrative representative of each of the 11 institutions visited. The purpose of the first questionnaire, used with the administrative representatives, was to collect data on the caseworkers' practice environment. The second, administered to the practitioners, dealt with their views on voluntary sterilization. The final questionnaire, also administered to the practitioners, concerned their professional practice in the last two voluntary sterilization cases (vasectomy or tubal ligation) they had dealt with.

In order to systematize the case study, the questionnaires were drawn up on the basis of two working hypotheses developed out of the generic literature on social work and on the problems of voluntary sterilization. Starting with the "psychosocial" concept that is widely used in casework and the variables involved in family planning, the following hypothesis was formulated:

The exploration grid of caseworkers in applications for voluntary sterilization is multidimensional, covering the medical, psychological, economic, moral and legal aspects; it considers the applicant as an individual and the social system: namely, the couple, the family and the community.

A second hypothesis is worded as follows:

In the interviews relative to voluntary sterilization applications the caseworkers go through an assessment process; in other words, the caseworkers make comparisons with predetermined norms.

Explanations are necessary here. As I have said, voluntary sterilization is a relatively new phenomenon for which precise norms have not yet been established. For example, it may appear relatively simple to predict the medical success of a sterilization operation, yet it is much more difficult to predict the short- and long-term "psychological" success of that operation. The decision for and the psychological effects of voluntary sterilization as a method of contraception involve numerous variables that others find almost impossible to grasp adequately. In this context, given the importance that social work has always placed on the principle of self-determination, it could be assumed that the caseworkers used an approach based on a self-determination model rather than an assessment model.

However, the main authors on casework Florence Hollis, Ruth Elizabeth Smalley and Helen Harris Perlman<sup>3</sup> suggest

casework relies, from the standpoint of methodology, on an approach centred on a diagnosis made by a professional. Furthermore, casework is very ambiguous in its definition of the principle of self-determination, as pointed out by Scott Briar and Henry Miller.<sup>4</sup> According to them, self-determination is used as an expedient when there are no data on which to base a prediction, or as a therapeutic technique; not as an absolute value. Consequently, it seemed truer to the tradition of the profession to assume that in this new field of practice with respect to voluntary sterilization, caseworkers use the assessment method.

The following data were collected on the practice milieu in which caseworkers operate. The 11 institutions in which these professionals work recognize voluntary sterilization as a method of contraception. This is an important fact when we consider that until very recently these institutions were either explicitly defined as denominational (Roman Catholic) or largely influenced by Catholic thought. It is a known fact that the Church allows sterilization as a method of contraception only in very special cases.<sup>5</sup>

Though these institutions may permit voluntary sterilization, they nevertheless do not allow it "on demand." There are internal regulations varying in scope from one location to another. In some cases, the rules are patterned on those of the American College of Gynecologists and Obstetricians.<sup>6</sup> In other

cases, there are prescribed procedures whereby some applicants must have an interview with a representative of a helping discipline (social work, psychiatry or psychology).

The administrative representatives interviewed for this study all recognized that, as a profession, social work is entitled to intervene in consultations concerning an application for voluntary sterilization. The main reasons that have been advanced mention the psychosocial character of contraception and the expertise that social workers have developed in interviews of a psychosocial nature.

On the whole, the practitioners' answers concerning the work context and social work as a profession were similar to those of the administrative personnel interviewed. With one exception the professionals had a very positive view of voluntary sterilization as a method of contraception. Seventeen of the 18 practitioners said that they liked to work with this type of application, and 15 out of 18 said that if necessary they personally would undergo a tubal ligation or a vasectomy.

It should be noted that the all caseworkers who responded had learned about voluntary sterilization on their own, thus implying that, apart from the generic methodological framework, including professional values and interview techniques, their social work education had not given them the necessary information for this practice.



With regard to the approach used in sterilization cases, the data collected confirmed the two hypotheses. Caseworkers take a multidimensional approach to their exploration of applications submitted to them, and they use an assessment approach. The study found that caseworkers are particularly concerned with the psychological dimension, showing interest in questions such as the significance of sterilization for the individual and the couple, and the anticipated psychosocial effects. Care is taken to explain to the applicants that a tubal ligation or a vasectomy may serve as a method of birth control but this procedure alone could not be expected to solve all other difficulties, whether actual or latent. As a general rule, thought is given to the possible consequences of sterility in cases where the spouse or the children may die, or in the event of divorce and remarriage. There is also discussion on how the couple decides whether the man or the woman will be sterilized.

According to the research data it seems that the "moral" variable was overlooked. This may be surprising but also explainable by the fact that Quebec has been strongly influenced by Catholicism and is now going through a transitional period.

The legal aspect has scarcely been explored, and then only technically in connection with the authorization forms required by the hospital centres and doctors. This point should be kept in mind, particularly since this operation is legal in

Quebec (it is covered under the health insurance plan) and since it has not been proved that the hospitals have been authorized to establish the conditions under which sterilization can be performed (except in the case of medical contra-indication). Doctors still have the right to refuse an operation, except when the patient's life is in danger. However, the hospital centres cannot definitely refuse to make available to the public the full range of their services. In the United States, legal action has been taken against hospitals that have refused to perform a tubal ligation on certain patients.<sup>7</sup> A few hospital centres in Quebec sometimes require that the applicant consult a case-worker or a psychiatrist, and bring the spouse to the interview.

Given the "advocacy" role recommended in recent social work literature, one might have thought that social workers would have drawn the public's attention to these questions rather than comply with regulations set down by the hospitals. It should be noted, moreover, that the practitioners whom I met--with a few exceptions--do not work exclusively in family planning and that social action of any scope requires a regrouping of forces. The practitioners interviewed all said that they felt isolated in a field of practice where there are still no traditions or coordinated effort. It seems to me that this is an area where action could be taken by the social workers' professional associations and by agencies involved in family planning.

The economic aspect of voluntary sterilization was mentioned in almost all cases. In this connection, as things now stand, social work is perhaps the only helping profession that has had experience in this investigation; perhaps this is one of its original contributions.

The medical question is always explored, not in order to discuss medical problems but to ensure that the clients have clearly understood the information given by the doctor, and that they are well aware of the consequences of the operation. This role can be viewed as a further contribution by social work, although it could also be argued that this aspect does not concern social work.

What can be concluded from the fact that on the whole social workers use a varied exploration grid? It appears that this multivariable approach is consistent with the theory of social work; by definition social functioning leads to a consideration of the various aspects of the client's situation. Hence, in my opinion, we can speak of the "multidimensional character of social work," and bear in mind that in dealing with applications for voluntary sterilization practitioners have been true to the tradition of their profession.

Lastly, it should be noted that on the whole the respondents considered not only the client as a person but also his immediate social system, namely, the couple and the family.

Here again, social workers have conformed with the social work approach which sees "man interacting with his environment." However, this leads to the question of whether voluntary sterilization is a decision to be made by the individual or the couple. Most of the practitioners answered that it was a decision for the couple. Though this position may be justified from the point of view of a social worker accustomed to studying the interaction between an individual and his environment, it remains to be established whether it is consistent with the legal rights of an individual. More in-depth studies will be needed to clarify this point.

As for the second hypothesis, the study verified that social workers use an assessment approach to voluntary sterilization. This means that they compare the data obtained from the client with predetermined norms, giving their expert opinion as to whether or not the application is appropriate. This assessment is then communicated to the doctor who must decide whether or not to agree to the operation. Although the doctor is fully responsible for granting or refusing the operation, one might think that where interdisciplinary consultations are concerned, the social worker's opinion carries some weight in the doctor's final decision. Hence, in the assessment and recommendation process the social work professional may go against the client's wishes when the latter does not agree with the social worker's opinion. According to the study data, this situation

arose only once in the 33 cases considered for research purposes.

How can this fact be explained? The various comments received during interviews with the practitioners led to the following interpretation. Although social workers use a formal assessment and recommendation model, they still adhere to the principle of self-determination. Consequently, they have a tendency to reason as follows: "In this case, ligation poses a risk, given the client's psychological vulnerability. However, this person has been well informed on the subject of sterilization and is still persisting in her application, saying that she is prepared to accept the consequences. Therefore I shall enter on the file that despite my reservations I do not oppose her application." This might be viewed as an attempt to reconcile the assessment model with a respect for the client's right to self-determination.

In my opinion this type of reasoning reflects the ambiguity of the casework process. On the one hand, caseworkers adhere to the medical model by making assessments and recommendations, and on the other they claim to recognize the principle of self-determination.

I believe that to solve this dilemma social work should clarify its methodological position, particularly in a field of practice which, unlike abortion, is not subject to legal constraints.

In order to stimulate discussion on the subject, I propose two models for the role of the caseworker with respect to applications for voluntary sterilization: the assessment model and the self-determination model.

#### The Assessment Model

This model refers to the usual action approach of social work. The practitioner compares data presented by the client with pre-determined norms. His exploration covers the various variables related to the psychosocial aspect of voluntary sterilization, i.e., the legal, moral, medical, psychological and economic variables. Obviously the caseworker does not judge the medical or moral relevance of an application since these aspects do not come within his field of competence. Rather, his exploration tries to establish whether there are problem areas in this field. If there are, he uses referral--the basic technique in casework, advising the client that he should consult a professional in the discipline concerned for a more thorough analysis.

In this model the caseworker defines his role as that of an expert. His authority flows not only from his know-how but also from society's recognition of his competence as a professional. In the interview the practitioner clearly situates his role, explaining to the client that he will examine with him the psychosocial relevance of his application for sterilization and that he will give his professional opinion. In cases where

the hospital or doctor has authorized him to make recommendations, the caseworker informs the client that he must make a report. The client should be forewarned about the consequences of a negative recommendation and of any recourse he may have.

Once it has been identified and selected, the assessment process involves specific methodological obligations: the norms used by the caseworker are clearly determined and, if he has been authorized to make a recommendation, the report submitted to the doctor and to the client is specific: either sterilization is or is not recommended on the basis of a specific reason.

The limitations of this applied approach in the field of voluntary sterilization are evident here. Indeed, in this connection it is not at all certain that it is possible to define psychosocial norms that are not arbitrary. Furthermore, the role of authority (expert-client) that the assessment implies, hampers the helping relationship inherent in social work objectives. Finally, to be sterilized is a private choice and it may be difficult for social casework--which has traditionally emphasized the defence of individual rights--to adapt itself to such a model in a field where there are no legal constraints.

However, given recent developments in legislation, it may happen that social work will be called upon to use such an assessment model in some specific cases, such as applications by adults under 25 years of age. Social work would then need to

clarify its assessment criteria, thus curbing any reliance on the practitioner's personal norms and values. In an assessment process that is not based on clear guidelines, this is an ever-present danger. Florence Haselkorn writes:

It is clear that at the present time it is our value biases and not knowledge or experience that guide us, since the area of counseling in family planning is relatively unexplored by social work.<sup>8</sup>

#### Self-determination Model

This model is based on the Rogers school.<sup>9</sup> It consists of helping the client to clarify his own aspirations and to form his own reactions to the various current standards of his environment. In this process the caseworker establishes himself as a "helper" and not as an expert who is going to establish the merits of an application. His authority flows from the client's confidence. With the client's consent he passes on to him the objective information he has (such as legal norms). If the applicant so wishes, he may be referred to other disciplines for more in-depth help.

The caseworker does not decide on the appropriateness of an application for sterilization since, in this model, there is no right or wrong choice, objectively speaking; the client's decision is regarded as valid. Consequently, the professional does not adhere to the principle of making a recommendation to a doctor or a hospital. However, if a written report is required



by the institution, he or she notes in the file that he and the client together have thought over the application and that he recognizes the client's right to decide personally whether or not he should persist in his application.

There are advantages to this model. It squares with the principle of self-determination and follows the present trend of the helping professions towards the affirmation of an individual's capacity to assume responsibility for his own development and the consequences of his acts. It also does away with arbitrary decisions in a field where there are still numerous controversies. It forces caseworkers to clearly situate their role in terms of an individual's rights, thus avoiding any pretence. For example, to solve what he or she sees as a contradiction, a practitioner uses the following technique: in cases of a recommendation, he advises the client right at the start of the interview that he will not oppose the application since he wishes to respect the client's decision. Apart from the ethical considerations that it raises, such a procedure, if the right is given back to the client, frees the competent authorities of having to cope with all dimensions of the problem, and does not afford an opportunity for the social service department to clarify its anticipated role.

### Conclusion

In this article I have presented a brief summary of research

done on the practice of social workers in Quebec in conjunction with applications for vasectomies or tubal ligations. In an attempt to solve a dilemma observed among practitioners with regard to their practice in this field, two mutually exclusive models have been proposed. The first focuses on assessment and the second on self-determination. By separating, from the standpoint of methodology, assessment from counselling based on self-determination, the counsellor on voluntary sterilization could more easily situate his role and thus better help the client to profit as much as possible from his intervention. The assessment model does not do away with the helping relationship, but it may make it more difficult at times. In my opinion, what does run the risk of harming the action taken by social work is the uneasiness felt by practitioners in reconciling the requirements of assessment with those of affirming self-determination. A clear view of the methodological approach chosen would enable the caseworker to explain the rules he or she is planning to follow not only to the client but also to the doctor and the institution as well.

## FOOTNOTES

<sup>1</sup>Lydia Rapoport, "Education and Training of Social Workers for Role and Functions in Family Planning," in K. Kendall ed., Population Dynamics and Family Planning (New York: Council of Social Work Education, 1971), pp. 128-146.

<sup>2</sup>Marie Berlinguet "La pratique des travailleurs sociaux du Québec dans les requêtes de stérilisation volontaire," (doctoral thesis, University of Toronto, 1975).

<sup>3</sup>Florence Hollis, Casework: A Psychosocial Therapy (New York: Random House, 1964); Ruth Elizabeth Smalley, Theory for Social Work Practice (New York: Columbia University Press, 1967); Helen Harris Perlman, Social Casework: A Problem Solving Process (Chicago: University of Chicago Press, 1957).

<sup>4</sup>Scott Briar, and Henry Miller, "Problems and Issues in Social Casework" (New York: Columbia University Press, 1971).

<sup>5</sup>Bernard Haring, "Medical Ethics," South Bend, Indiana: Fides Publishers Inc., Notre Dame University, 1973).

<sup>6</sup>Up to 1969, this college suggested the following age and parity criteria for obtaining a tubal ligation: women 25 years of age with five children; woman age 30 with four children or a woman age 35 with three children. These norms were adopted by several Quebec hospitals and are known as the rule of "one hundred and twenty," that is, the age of the woman, multiplied by the number of children should be more than 120. These norms are now tending to disappear.

<sup>7</sup>Information provided in a personal letter from Evelyn E. Briant, Director of Services, Association for Voluntary Sterilization, New York.

<sup>8</sup>Florence Haselkorn, "Values issues for Social Work in Family Planning," in F. Haselkorn ed., Family Planning Readings and Case Materials (New York: Council on Social Work Education, 1970).

<sup>9</sup>Carl R. Rogers, "Client Centered Therapy," (Boston: Houghton Mifflin, 1951).

## STERILIZATION AND THE ROLE OF THE SOCIAL WORKER

Rolande Morin, "DEC" en Assistance Sociale

### Author's Note

The following article discusses my work at the Jonqui re Social Services Centre in Jonqui re, Quebec, during the early 1970's.

The material dealing with the medical aspect of the article was prepared with the cooperation of Dr. Yves Lemay, general surgeon, Dr. Paul Dumont, gynecologist (both with the Jonqui re Hospital Centre) and Dr. Desmond Paradis, gynecologist (Chicoutimi Hospital Centre). The author emphasizes that medical information should be given clients by professionals in the field of medicine. In the absence of such professionals in the project described, however, this information was provided by the social worker.

Between 1970 and 1974, 415 cases were handled under the experimental program. In 1974 more than 235 people used the family planning service.

The method was as follows:

1. An evening meeting would be held to provide medical and social information about sterilization for a group of 10 to 15 people who had requested such information during the month.
2. During the month following the group meeting, couples wishing psycho-social counselling were met with individually.

3. A report was sent to the doctor performing the sterilization.

In this project we worked to ensure that the couple's approach to sterilization was informed and objective.

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The effectiveness of planned parenthood is not solely dependent on contraceptive information, or even on the effectiveness of the method chosen, but involves an entire system of social and psychological factors. Clearly, therefore, the choices to be made affect a couple's sex life (which should be a means of personal development) even if, because of birth control, the couple's sexual activity is no longer necessarily associated with the possibility of pregnancy. These choices also depend on both the man and the woman in the relationship, although too often only the woman bears the consequences of a pregnancy.

Preventive action to promote education about marriage, parenthood and sex seems essential in order to improve the quality of a couple's life, and as a consequence the quality of their children's surroundings. In many cases it would be detrimental to ignore the couple, assuming that they are solely responsible for family planning.

Fear of pregnancy is so real and assumes such importance in sexual encounters that it is usually blamed for difficulties and so long as it is a factor, one need look no further for the

origins or causes of sexual problems. Far from ruling with community help, a couple's primary responsibility calls for it and demands it more than ever.

Though limiting the birth rate is the immediate objective of all true planned parenthood, it must encompass more than that because family planning has immediate, direct effects on the development of the couple themselves, on the quality of the family atmosphere and the children's education, and on the improvement of the community itself.

Without a doubt social workers, with their training and skills, can educate their clients, providing explanations and considerable direct assistance in the area of family planning. As the social services are concerned with the family, social workers must aid individuals in controlling their own reproduction in a responsible and independent manner. The involvement of social services in family planning should be seen as the opening up of a new field of preventive work. Although the immediate objective of education in family planning is to train responsible parents, it also claims to better the quality of life for both individuals and the whole community.

The social services should be in the vanguard of promoting family planning policies and programs which are humane and accessible to all. Family planning must be seen as a health measure centred on the maintenance and development of family life.

In the context of social policy, the primary objective is to create conditions favourable to the satisfaction of social needs and social growth. A family planning policy must be concerned as much with the conditions in which individual freedom is exercised as with the ability of each individual to exercise this freedom in a responsible manner -- that is, with preventing the social dysfunction caused by irresponsible sexuality.

If it is to be fully responsible, parenthood cannot be totally left to chance and to the biological rhythms themselves. This implies an understanding of biological processes and calls for mastery of natural human drives by reason and will. In order to bring out the human values involved, physical, psychological moral and socio-economic factors must be carefully weighed.

The physical capacity for, and the function of, procreation are important personal values. However, in a given situation these values compete with others considered at the moment to be more important: safeguarding the wife's physical or mental health, providing effective protection against the birth of deformed or retarded children, promoting affection within the marriage through confident, risk-free sexual activity, and so on. At the same time, sterilization may appear to be the only -- or unquestionably the best -- means of resolving the conflict. However, a word of caution: a couple choosing sterilization in the hope that it will completely change their sex life may find that afterwards they have

the same problems and are greatly disappointed as well.

Dr. Nicole St-Jean explains it this way:

From the psychological point of view, sterilization is not a neutral occurrence. It is an important decision which arouses in varying degree childhood fears of castration and impotence, often accompanied by decreased self-confidence. The average man can of course deal adequately with these problems and master them, but to try to disregard them and not mention them would be to render oneself a very great disservice. For a man who is worried [about being sterilized] it is much more difficult, not to say impossible, to discuss his problems after the operation; perhaps a current practice should be to strongly recommend a psycho-social interview before, and perhaps after the operation.<sup>1</sup>

It seems clear that family planning is not a mere technicality; in and of itself it affects the development both of the couple and of each partner separately as well as that of other family members, the family atmosphere, and the community itself.

The role of the social worker is:

- To prevent deterioration in the life of the couple and the individual;
- To improve the quality of their lives;
- To help the couple attain fulfilment in their sex life;
- To achieve satisfactory and constructive communication;
- To improve the individual functioning of each of the partners so as to encourage their more effective functioning as a couple;
- To prevent abortions;



-- To prevent the psychological trauma of an unwanted pregnancy; and

-- To encourage a fuller development of the children.

These are the objectives of psycho-social counselling, which may be summarized as "helping the couple make their decision objectively," mainly in cases of sterilization.

From personal experience in this field, I have found that couples request sterilization when they have had the desired number of children or, in many cases, after having exceeded this number, using several contraceptive methods with varying success. I feel that abortion and sterilization should not be classified among family planning methods, since both abortion and sterilization are used to control a given situation. In my opinion, a family planning method should be a reversible process. At present, sterilization is not an operation which is 100 per cent reversible. I also believe that abortion cannot be such a method, because it is irreversible. Abel Jeannière explains:

Concerning abortion, the aim of the law should not be to suppress an action considered to be reprehensible, but to guarantee protection of maternity which will permit the gradual growth of the child, for adulthood represents the conclusion of a lengthy process, all of which should be the community's concern. To effectively prevent abortion means to work in a number<sub>2</sub> of directions which are concrete as well as immediate.

In the process of psycho-social counselling the social worker should weigh the socio-economic factor carefully with regard to a sterilization decision, not only because poverty is

a relative concept, but also because it is a condition that may be altered both by the individuals themselves, and by the intervention (albeit still too insufficient and ineffective) of public authorities and agencies. To attain the objectives of psycho-social counselling, the social worker should assess the particular problems in a given home: that is, he should preserve and foster marital affection and, indirectly, the development of children already in the family. Sterilization may be justifiable in cases of chronic poverty, which almost always affects the health of the parents and children.

In all of these cases, who should decide about the possibility of sterilization? The individual's right to choose an irreversible method should be recognized, and this choice made with the free consent of the parties. For a social worker, this also involves enabling and encouraging clients to adjust their attitudes in the light of the information available on the subject, so that they are as aware as possible of the risks and advantages of their choice. The chief objective of social work is to respect the independence of people and groups and to develop their sense of responsibility.

This conclusion is substantiated by research done by David Rodgers and Frederick Ziegler which showed beyond any doubt that vasectomy involves more than a medical procedure: it requires the expert opinion of a trained team, informed on matters of

sexuality and birth control.<sup>3</sup> The social worker should know if there are counter-indications to vasectomy. However, he should be able to judge their relative importance. Vivian Codden is aware of the importance of indications and counter-indications in psycho-social counselling:

Social workers should not be too quick, however, to reject couples who manifest some degree of anxiety, insecurity, or difficulty in their relationship, because any surgery is likely to be accompanied by some anxiety; no intimate relationship is completely free of problems; and no individual is completely free of sex-role confusion or insecurity. Policies can be flexible if the couple is provided the opportunity to discuss fully their expectations and anxieties, if they appear to be comfortable and firm in their decision. It is important that social workers not project their own values or bias on their client.<sup>4</sup>

#### The Moral Aspect

Marc Oraison, after reading the Simon Report<sup>5</sup>, notes that fresh thinking is necessary on morals because, in his opinion:

Human sexual behaviour is not limited to the physiological level. Unlike that of animals, human sexuality goes well beyond the biological framework. A couple's sex life and fertility have a bearing on contraception -- that is, sexual relations may be enjoyed for their own sake, in the certainty that they will not lead to an unwanted pregnancy. The means of making this possible is of little importance. The moral value of behaviour does not refer to a physiological rhythm, but to the meaning which it is given.<sup>6</sup>

In view of this Christian moral ethic, what must the attitude of the social worker be? Clearly, the social worker must set aside his own values. He must take into account the beliefs and feelings of the married couple who feel that, as a

result of special circumstances, they are being confronted with what seems to be a conflict of duty. For example, the requirements of marital affection must be reconciled with those of responsible parenthood. An effort must be made to explain how moral principles of continuing validity apply to the variety of concrete situations in which people are involved from day to day. The social worker can impartially analyze the social situation, which is often presented as a reason for sterilization for contraceptive purposes when the reason is something else altogether.

Following an interview with a social worker, psychological or psychiatric consultation may be necessary. The social worker must not hesitate to refer the couple to a specialist. My experiment at the Jonquière Social Services Centre showed that in certain cases a short waiting period is necessary in order to make sure of the couple's motivation. It is of prime importance that the final decision concerning the sterilization of one or the other be made by the couple. Vivian Codden comments: "The final decision should be left until the couple have been fully informed."<sup>7</sup> I emphasize that in order to make an irreversible decision, one must feel at ease with oneself; where there is doubt, it is better not to act. Often in such a case psychological problems appear.

When sterilization is indicated after psycho-social counselling, and if there is no serious medical consideration favouring sterilization of the woman rather than the man, the

couple is completely at liberty to choose vasectomy or tubal ligation. Based on my experiment, I would say that the emphasis must be on acceptance, information, support, advice, education, and prevention.

It must be stressed that the psycho-social interview makes it possible to detect other problems with suitable references.

The predominant reasons for couples requesting sterilization in the 415 cases evaluated during four years of the experimental program are as follows:

The couple did not want any more children. (Most such couples said that the third child is "bad luck". They did not plan before the third child, and made such comments as: "Now we have our family". "It is easier to have children than to raise them." "A new pregnancy means abortion." "I'll go crazy if I become pregnant." "I'm so afraid that I'm frigid." "I'm leaving my husband." "We'd rather have fewer and raise them better.")

Sex is unsatisfactory and manifested in aggressiveness, nervousness, frigidity, absent father, crying mother, disturbed family atmosphere, drinking problems, drug abuse, and so on.

The causes of this dissatisfaction: conditioned sexual relations, reduced frequency in sexual relations, unpleasant contraceptive method used, lack of knowledge of methods, fear of fertility (on both sides), denial of sexual relations, no cooperation from either person, different needs or requirements, frigidity or

sexual impotence, premature ejaculation, difficulty in maintaining the erection at the moment of penetration (fear of the woman becoming pregnant).

Sex was important to most of the couples encountered in the experiment; it is a very deep bond.

Changes that couples expected might result from sterilization, in order of importance are:

1) for the other individual: 2) as a couple; 3) as an individual.

Couples said they were confident that the desired change after sterilization would follow naturally once the "morbid" fear of a new pregnancy was removed.

#### Ethical Considerations

Except for three cases, none of the couples were at all concerned. They told us: "It is more moral not to have children when you don't want them, than to bring into the world those who will be unhappy."

#### Reaction after Sterilization

Reactions couples most often expressed to us during the follow-up were:

- They were pleased to have relations when they wished and without constraint.
- The changes were more than quantitative.
- "I do not feel diminished because I have had a vasectomy; the proof is at home (number of children)."

- The method's irreversible aspect did not frighten them: on the contrary, they said: "It is what we want. We've done the best we can."
- Several couples, in each of which the husband had had a vasectomy, went on a short trip when the danger of a new pregnancy was removed. The wives expressed it this way: "It was marvellous. I didn't really know him. I was afraid to approach him before, I was so reluctant to have any more children." One husband told us:

"If I had known the good it would do, I would have asked for a vasectomy before. Several conflicts between us would never have existed. The fear of an unwanted pregnancy poisoned our sexual and conjugal life for 10 years (this was a couple 40 years old). Now my wife is more patient; she shouts less at the children, who are more relaxed and so on."

It is noted in the publication Canada's Mental Health that, "nowadays women complete their child-bearing period earlier. It is estimated that approximately 75 per cent of couples complete their child-bearing period before the wife is 30 years old."

"While at age 30 a couple may have the number of children they want, they have often gone beyond that number, and they still have 15 years of potential fertility remaining. What can this couple do to avoid further unwanted pregnancies? Vasectomy or tubal ligation is the most frequently adopted solution."<sup>8</sup>

In closing, it seems appropriate to quote what the Quebec Family Planning Federation considers to be a positive philosophy regarding the family:

If we want to ensure that each stage of the family planning process achieves its objective, that information

is complete and available to all, while at the same time appropriate to the situation, and that techniques and services are built around sustained motivation, family planning must be among the principal concerns of the family, in an evolutionary and dynamic society where new values are developing. These concerns, which have the effect of encouraging the development of love and a sense of responsible parenthood, mutual respect between, and development of, the parents, become part of the daily life of Quebec families: communication between family members, the roles of the couple, the place and role of the child, sexuality, family responsibility toward the development of the entire community.<sup>9</sup>

Here, then, is a field of work offering the social worker an opportunity to act preventively.



#### FOOTNOTES

<sup>1</sup>Canadian Association of Social Workers, "CASW Policy Statement on Family Planning," March, 1974, (Pamphlet).

<sup>2</sup>Marcel Marcotte, La vasectomie et la morale," Relation, February 1973, p. 54.

<sup>3</sup>Nicole St-Jean, "Vasectomie: questions importantes," Echos, published by the Quebec College of Physicians and Surgeons, p. 50.

<sup>4</sup>Abel Jeannière, "Légaliser l'avortement," Projet, Paris, March 1974, p. 50.

<sup>5</sup>Pierre Penard, "Vasectomie et Service Social," Unpublished paper, August, 1974.

<sup>6</sup>Vivian Godden, "Very Private Decision," Good Housekeeping, May 1972, p. 85.

<sup>7</sup>Pierre Charron and René Julliard, eds., "Sur le comportement sexuel des Français," Rapport Simon, Montreal: 1970.

<sup>8</sup>"Marc Oraison, Foi et Vie, December 1, 1972, pp. 29-30.

<sup>9</sup>Vivian Godden.

<sup>10</sup>Department of National Health and Welfare, Canada's Mental Health, September-October 1973, p. 5.

<sup>11</sup>Michel Perreault, Politiques de Population et Mesures sociales," Montreal: Fédération du Québec pour le planning des naissances, May 17, 1974 (unpublished paper).

## ABORTION AND PSYCHOSOCIAL COUNSELLING

Denise Richer, M.S.W.

Abortion is a highly controversial subject. Opinions range from total rejection of abortion as a form of murder, to abortion on demand, where the decision is seen as being solely the woman's responsibility. Beyond the biological, moral, ideological and legal aspects lie real-life experiences; this aspect of the problem should be the focus of the social worker's attention in his or her role as counsellor on a multidisciplinary team. For this social worker, the question of abortion cannot be expressed in terms of "for or against." It is clear that individuals and their values must be taken into account. Just as a doctor cannot be forced to perform an abortion if this act goes against the doctor's conscience, we should recognize that the social worker has the same right at the counselling stage.

Social workers' involvement in the matter of abortion is obvious: it is based on the recognized role of social work as profession designed to serve individuals and their environment--in other words, a profession that comes into play whenever a problem has a psychosocial dimension. Eighty or even 90 per cent of the time, it is apparently for reasons of a psychosocial nature that a pregnant teen-ager or woman seeks an abortion. Strictly medical considerations, including those of a psychiatric nature,

generally do not account for more than 10 per cent of the cases. These facts emerge from research done in the United States and Canada from statistics gathered in hospitals where therapeutic abortions are performed. The experience I have gained in four years as a counsellor with the family planning service of the Notre-Dame Hospital in Montreal confirms these percentages.

Although about 100 therapeutic abortions are performed in the Notre-Dame Hospital each year, every year more than 400 women turn to our service seeking an abortion. Because of my experience, I can testify to the importance of the social worker's role as a source of help for women who think that abortion is the best solution to the problem posed by their pregnancy.

Many women can make the decision to have an abortion, find suitable medical help, and work through this experience in a positive way by themselves or with a close friend or relative without seeking assistance from a social worker. However, in view of the society in which we live, and the socio-cultural factors which have such an influence on our behaviour, I think that psychosocial counselling should be readily available to any person who wants it. It is also important to provide a follow-up service in order to evaluate the abortion experience, any possible regrets or feelings of remorse, and the way in which the woman has managed to readjust to her former way of life.

### The Social Worker's Role as Counsellor in a Hospital Centre

In 1969 an amendment to the Criminal Code legalized therapeutic abortion in Canada when continuation of the pregnancy would endanger or probably endanger the life or health of the woman, on condition that this abortion be performed in a accredited hospital after having been approved by a committee of three doctors.

Everyone knows that this law can be interpreted in a liberal or restrictive way depending on the meaning given the term "health" of the woman. This means, in practice, that a therapeutic abortion may be approved in one hospital and refused in another. We also know that there is no legal provision requiring a hospital to set up a therapeutic abortion committee. In fact, only 11 French-language hospitals (eight of which are in the Montreal region) have such a committee. This means that each year a large number of abortion requests come into Montreal from all corners of the province of Quebec. Many women are referred by their family doctors and know nothing of the actual situation they will have to face when they arrive in Montreal. Because they have been recommended by their doctors, they believe that their abortion requests will be approved immediately and that they will be hospitalized without delay. At this point, we must emphasize the role taken on by some social service centres located outside Montreal with regard to abortion requests coming from the areas they serve. The social service centres and hospital

facilities have begun to coordinate their work, resulting in more complete assistance for women who want therapeutic abortions. These centres can exert pressure on hospitals in their regions to persuade them to provide therapeutic abortion services for the population they serve.

The social worker, conscious of their role in society at both the preventive and curative levels and concerned about citizens' rights to take advantage of legally recognized services, should become a spokesman for women who want to have an abortion under medical and psychological conditions that take into account their dignity and needs.

What, precisely, is the role of a social worker in a hospital centre? I can best explain this by referring to my own work.

In order to be as familiar as possible with the situation of a woman who wants a therapeutic abortion and with the impact of this unwanted or unaccepted pregnancy on her present and future behaviour, the therapeutic abortion committee asks for a psychosocial assessment and a psychiatric assessment for each case. In the light of these assessments and the recommendations of the social worker and psychiatrist, and depending on its own interpretation of the law, the therapeutic abortion committee recommends or does not recommend an abortion according to whether or not it feels the woman's pregnancy represents a danger to her physical or mental health.

In this context, it is easy to understand the problems faced by the clinician at the assessment stage. Two realities come face to face: the personal, family and social situation of the person concerned and the legal standards of the therapeutic abortion committee; self-determination seen as a growth concept and external rules which are regarded as possible hindrances to such growth.

We have to help the pregnant woman clarify her situation and her feelings toward the abortion and assist her in identifying and solving her problem, while at the same time confronting her with the possibility of a rejection by the therapeutic abortion committee. The people concerned do not find it easy to accept or live with this aspect of the situation. To the understanding and supportive attitude of the social worker, there is grafted another role which must be brought out clearly during the interview. This role is that of an "advocate," where the social worker adopts the interests of the woman concerned and is ready to voice and defend them before the abortion committee.

During the assessment interview, it is essential to gather as much information as possible in order to gain a better understanding of the woman who is asking for an abortion. We need to know:

1. The patient's previous behaviour at various stages in her life (childhood, adolescence, adulthood) and in various spheres of activity (as a student, worker, wife, mother); and

2. Her present behaviour in the personal, family, and social contexts, in order to foresee as completely as possible her future behaviour in the face of a new responsibility.

This information, considered in conjunction with the woman's feelings about her unwanted pregnancy, her own reactions and those of her friends and family, enables us to form a fairly complete picture of the situation she is experiencing. We can safely say that it is the woman concerned who works out her own diagnosis and that she is the one who knows the answer to her own problem.

At the social counselling stage, the social worker must prepare the woman for her psychiatric interview. The psychiatrist is often seen as a threatening person in front of whom it is better not to talk too much about your problems, to minimize an often significant state of depression--a person in front of whom you must appear in your best light. Once the psychiatrist's role has been explained and put into context, this interview is generally well received. You might say, "These women have no choice." I would have to answer, "You're right." However, I do think we can make this a positive step, giving a better picture of the psychiatrist, who comes to be seen as a human being capable of listening and helping. Comments made by various women and teen-agers allow me to confirm this hypothesis.

What should the social worker's attitude be regarding the abortion committee's decision when the committee refuses to

grant the woman's request because it considers that the pregnancy does not endanger her mental health, and decides not to accept the recommendations of the social worker and the psychiatrist? It is important to note at this point that rejections by the therapeutic abortion committee are based solely on its interpretation of the concept of "mental health."

The social worker should not feel responsible for the abortion committee's decision. At the Notre-Dame hospital centre, the social worker has chosen to be the one to inform the patient of the outcome of her request. This function is sometimes filled by the nurse or secretary, except in cases of rejection. It seems logical to me that the social worker assumes this responsibility. The social worker is generally more familiar to the person concerned, considering the supportive role he or she has played during the waiting period. The social worker's training and ability to understand and accept allow him to bear the brunt of the often very hostile reactions of the woman refused an abortion. The pregnant woman sees this rejection as proof that she has not been understood and accepted. Although warned at the very first meeting about the possibility of a rejection, she had kept on hoping, and this hope is now suddenly shattered.

Conscious of our responsibilities and in accordance with our policy of respect for self-determination, we try to find other facilities that will provide the desired assistance. We attempt to



make arrangements with English-language hospitals in Montreal which usually agree to help the few people whose requests have been rejected. But sometimes we cannot obtain this service. Is the social worker at that point able to help the young woman continue her pregnancy? This has always proved impossible. The hospital as a whole and all of society are seen as the villains, and the social worker is part of this hospital and of society. We leave the door open and we tell the woman about resources outside the hospital.

#### Mixed Feelings Toward Abortion

As a general rule, I think that there are mixed feelings toward abortion in most situations, although to varying degrees. It is therefore important for the social worker to be aware of this aspect of the abortion question, so as to pick up non-verbal messages during the interview and be able to clarify them with the person concerned. These mixed feelings might be what I call "normal": mixed feelings related to socio-cultural factors, ambivalence which reappears every time an important decision must be made. In such cases, the feelings that emerge are proportional to the situation being experienced.

When teen-agers or women are asked what their opinions or feelings about abortion were before their present pregnancy, they often answer that they had never even thought about it. Others say that "it depends on the situation," intimating that the decision should be left up to the person directly concerned. Several women

who were against abortion say that they have changed their attitude because they are now directly involved. Most of these women are Roman Catholic, but they do not consider themselves bound by the Catholic Church's policy concerning abortion.

The mixed feelings may be more deep-seated. They may be tied to conscious or unconscious feelings of guilt, loss of worth, failure, or rejection. The child may be seen as someone who will satisfy needs for affection and dependence which have never been filled. Abortion will be seen by a passive-aggressive personality as a form of aggression. Although they are in a difficult situation, anxious about the future and often conscious of their faults and needs, some women will not go through with their chosen course of action; others will refuse hospitalization or, once hospitalized, will panic and sign their own release. It is almost impossible to predict some women's reactions with certainty. Their mixed feelings, in connection with their personality may lead them either to terminate the pregnancy or go through with it. My own personal experience, in addition to the experiences of those around me, has enabled me to adopt a calmer attitude toward this aspect of the problem, knowing that the woman will choose what she believes to be best for her, whatever her actual objective situation may be. Mixed feelings are generally more marked in cases where the abortion must be performed in the fourth month of pregnancy.

Abortion involves making a decision. For some women, this decision may be relatively easy; for others, it involves a re-examination of themselves and society. It often requires a woman to go from passive behaviour, in which she submits to difficult conflict situations, to active behaviour based on her needs and capabilities and those of the people dependent on her.

Whether the woman chooses to have an abortion or continue her pregnancy, her decision or choice may be felt as a loss: loss of the child, loss of self esteem or other's respect, loss of identity, loss of gratification. In contrast, to continue the pregnancy might mean loss of physical, psychological, family, and social well-being. The woman is alone in her decision. Whatever support she may receive from her friends and family, from the social worker or the psychiatrist, she knows very well that she is the one who must make the decision, who will experience the abortion and its repercussions.

Even thinking about having an abortion may bring about considerable feelings of guilt in some women. They are afraid of being selfish, of thinking only about themselves and their own needs. When you are a wife, when you are married and have children already, you believe that you must no longer function in terms of yourself, but rather, give yourself entirely to your husband and your children, silence any feeling of rebellion or aggressiveness with regard to situations which you consider to

be unjust. I think it is important, during the interview, to make the woman feel that she matters, that we do recognize her rights and her personal needs, and that we accept her as she is with her faults, her good qualities, her negative and positive feelings.

So far as I am concerned mixed feelings are not a counter-indication for abortion. Mixed feelings are perhaps a woman's lot. In order to minimize regrets or feelings of remorse, I point out to women who choose to have an abortion that they should keep in mind the reasons which motivated their decision, because once their problem is settled, they might easily think that they could have taken on the responsibility of the child without any difficulty.

#### Is Abortion Always a Traumatic Experience?

I think it is important to take some of the drama out of the abortion experience. People believe, or would perhaps like to believe, that abortion is always a very traumatic experience. Through my work I have come to realize that several external factors often contribute to making the experience more painful than it need be.

A woman who is pregnant with a child she does not want or does not accept and who considers abortion as a possible solution immediately faces this agonizing question: "Who can I turn to?" She may talk about it with her doctor, but he is usually not well informed about existing resources. Feeling

powerless to help his patient, he will often strike her as indifferent and unhelpful.

Her family, her friends? If she dares to talk to them about it, she finds they are generally as uninformed as she is. She looks in the classified ads for private agencies which offer abortion services in the United States but she soon realizes that she does not have enough money and that her borrowing possibilities are nil. She goes around in circles and gets worried because days count when an abortion is being considered. If she is fairly self-assured and makes her decision without too many mixed feelings, she may decide to go to an English-language hospital. If her pregnancy is not too far advanced, she will manage to get an appointment fairly quickly. Otherwise, she may be given a list of doctors who will see her at the office, or she may simply be turned down because of the length of the waiting list. It is often chance which brings her to the Notre-Dame hospital family planning service. Many women do not know that therapeutic abortions are performed in French-language hospitals. A great many do not know that a therapeutic abortion is legal and that the cost is covered by hospital and health insurance.

I mentioned that we receive an average of 400 abortion requests each year. The social workers have taken on the responsibility of "screening" telephone requests. Because of our experience, we can assess requests quickly. In this, the social worker's skills and qualification are put to maximum use. When

the situation presented to us does not seem to meet the therapeutic abortion committee's criteria, we feel it is our role to help the women find another source of assistance. We try to direct her to English-language hospitals in Montreal or to the United States.

French-Canadian women have become increasingly dissatisfied with the fact that they cannot have an abortion in the hospital of their choice--that is, a French-Canadian hospital. Most of these women speak little or no English, and this adds to their anxiety. They want their requests to be recognized and accepted by their own people. The current situation only increases the woman's guilt feelings. A rejection by us means that she does not, perhaps, have valid reasons for having a therapeutic abortion. An abortion in the United States may be even more guilt- and anxiety-producing. Some women see it as illegal. Obviously, an abortion in the United States is more accessible to those who have adequate financial resources, but there are women who may be so impoverished in the psychological and social senses that an abortion in the United States would be too traumatic an experience to be acceptable.

This "screening" is, to my way of thinking, a very important service; this is why we agree to devote considerable time to it. It is never a question of trying to solve the problem in a hurry. Sometimes, in view of the situation and the feelings expressed, we think an interview is desirable. We offer this

service even if the abortion will not be performed at the Notre-Dame hospital.

What does the woman experience in the first person-to-person contact? One feeling predominates: fear that the doctor, the social worker or any other member of the medical team will judge her, will not understand and will refuse to help her. Socio-cultural values and the anti-abortion attitude of a segment of society help to bring about or increase this anxiety. With teen-agers, single women, women who are separated or divorced, and with those who have become pregnant as a result of extramarital sexual relations, we find there is a desire to justify themselves in our eyes, to prove to us that they are not women of loose morals. They are afraid of being considered irresponsible, especially since in most cases they did not, for a variety of reasons, assume their responsibility for contraception.

A helpful, listening attitude, free from prejudice, will help take the drama out of the situation and lessen the woman's guilt and anxiety, allowing her to pull herself together to carry out her decision and continue to function as satisfactorily as possible, because for her, and for others, life goes on--there are friends, school, work, a husband, children. You have to eat and sleep if you want to hold out in the midst of your daily activities.

Despite the understanding attitude of the doctor, the

social worker and the psychiatrist, the sword of Damocles continues to hang over the head of the teen-age girl or the woman, and her family. What will the therapeutic abortion committee's answer be? The small number of therapeutic abortions done at the Notre-Dame hospital makes it possible for us to provide faster service at the assessment level, but the time seems very long indeed to the person who is waiting. The telephone calls we receive during this period are evidence of the anxiety experienced. These callers have only one purpose: to tell their troubles to someone who will listen. A woman's relief when she hears that her request has been approved shows how much the present abortion situation makes this solution even more difficult and painful.

Abortion must not become too easy and uncomplicated a thing; however, society through its laws, its institutions and its moral code, has set up its punitive structures well.

#### Anxiety Regarding the Actual Abortion

All the teen-agers and adult women we see are anxious about the medical aspects of abortion. For efficiency reasons, the interview with the social worker usually comes before the gynecological examination. Most women do not know about the techniques used in performing abortions. They sometimes have vague or false ideas which must be clarified. Abortions induced by saline injection at 16 weeks raise the most questions and cause the most anxiety. It is important for this aspect of the situation to be discussed



at the very first meeting with a member of the multidisciplinary team. In order to be more qualified to take on this responsibility, I have watched several abortions by saline injection, have been present at the various stages, and have seen a fetus after its expulsion. This experience is combined with theoretical information learned from the medical team. If the social worker cannot answer all the questions asked, or if what is needed is medical information that he or she is not qualified to give, the doctors and head nurse assigned to the family planning service are available. Many women worry about the medical risks involved in abortion: infection, hemorrhaging, sterility. When medical information is given at a time when the woman is very anxious and preoccupied with solving her problem, it does not always get through. I had always thought that the information I have was more-or-less satisfactory, I had always thought that it was received as such. However, the psychiatric counsellor, who sees all the women when they are hospitalized, told me that in a great number of cases he had had to go over all the medical information again. As a doctor, the psychiatrist can make the women feel a little more secure than the social worker can.

With teen-agers or women who have not had children, we find there is greater anxiety about hospitalization and the actual abortion. For teen-agers, it is almost always their first hospitalization and it is often their first time away from their mothers. All the women would like the abortion to be performed

under general anesthesia, but this is only possible in the first three months of a pregnancy. In spite of the painful aspect of an abortion by saline injection, teen-agers and adult women feel so relieved at the prospect of having their problem solved that they do not usually dwell on the negative side of the experience. Certain things may help reduce anxiety at the time of hospitalization: acceptance by hospital staff, and mutual support given by patients who share the same room.

#### Post-abortion Experiences

For a great number of women, the experience of an unwanted or unaccepted pregnancy is a momentary crisis which is completely resolved by the abortion. A therapeutic intervention can make abortion an experience of maturation and growth, rather than one of destruction and regression. Most women express a feeling of relief. They feel freed from the tension they have undergone; their depression disappears or improves in an appreciable way, especially in cases where the depression was acute. Students return to school; others go back to work; women who remain at home take up their family responsibilities again.

However, some women have "post-abortion blues," accompanied by feelings of guilt and doubts about the advisability of their decision. Other women are left with considerable feelings of guilt accompanied by great anxiety or depression. The most mentally and emotionally unstable women are the ones most liable

to fail to readjust after an abortion. We might call them "high-risk abortions." Does this mean that such abortions are counter-indicated? I think not. Going through with the pregnancy, giving birth and having the responsibility of a child might cause deeper disturbances in such cases. Let it suffice to call to mind post-partum psychoses and all the problems that arise with women for whom the birth of a child brings back earlier traumatic situations and who become totally incapable of functioning when they are faced with responsibilities that are too great. These women need a post-abortion follow-up, but they also need psychiatric treatment; however, we often run into lack of motivation or resources.

All therapeutic abortion services should be able to provide the population they serve with follow-up treatment. Experience has shown that small group sessions, after the patient has left the hospital, can help resolve certain conflicts that are still present concerning the unaccepted pregnancy and the decision to have an abortion. These sessions can take place at the same time as the post-abortion medical examination.

### Contraception

Abortions are generally needed as a result of contraceptive failures--failures in tubal ligations, vasectomies, oral contraceptives, IUD's, diaphragms, condoms, coitus interruptus, the rhythm method. Some of these failures do not involve any responsibility on the part of the woman concerned, for example, sterilization or IUD's. Other

failures result from misuse of the method or misunderstanding as is frequently the case, for example, with teen-agers or married women who use the rhythm method. Essential to the psychosocial assessment is a talk with the woman about her previous contraceptive behaviour in order to help her make a wise choice in future.

If the woman wants a tubal ligation, it is done at the same time as the abortion. I have learned through experience that you must be very careful when a woman asks for both a therapeutic abortion and a tubal ligation. Had she already made this choice before becoming pregnant, or is it a spur-of-the-moment decision made during a crisis? Is she asking to be sterilized in the hope that her abortion request will be more readily approved?

The social worker must follow his or her own philosophy in cases involving sterilization. While respecting the principle of self-determination, social workers must still be very careful when considering sterilization for a single woman or a young wife, even if she has one or more children. Loss of fertility in conjunction with the loss of the child may be too much to take in certain cases. Because of the conflicts which may arise, the time when a woman is involved with an abortion may not be the best moment for making such a decision. In my experience, it may be preferable to postpone the sterilization decision. If the woman does not change her mind, the social worker should be available for further counselling at the follow-up stage.

All women who choose the pill or IUD as a method of birth control are followed up, if they wish, by our family planning service. Those who come from outside Montreal are referred back to their own doctors.

Generally, we can confirm that when an abortion is performed as a therapeutic procedure, the rate of recurrence diminishes appreciably.

The following are reasons given by women who want a therapeutic abortion:

- Finances. Surveys carried out in Quebec concerning abortion reveal that economic reasons are not recognized as valid. I think there is a tendency to isolate the financial question without taking into account its psychosocial impact. In most cases financial insecurity is synonymous with emotional insecurity. It is related to feelings of loss of worth, powerlessness and rejection. This is the experience of welfare recipients and low-income families, whose situation is well known to social workers.
- Age (teen-agers or women over age 40).
- Interpersonal conflicts such as marital problems, parent-child problems; unstable relationship with the child's father.
- Emotional problems (emotional immaturity, instability, intolerance toward children, inability to give affection, strong fear of pregnancy and childbirth).
- Chronic or acute depression.
- Illegitimate or extramarital pregnancy.

--Psychiatric problems.

--Medical problems where the pregnancy represents a risk for the mother or child.

It would be wrong to think that abortions performed for medical reasons are better accepted, because often these are "wished-for" pregnancies. The woman who is warned by the doctor of the dangers that continuing her pregnancy might mean for her or for the child may be totally against abortion for religious or moral reasons. If the woman is ill, she may feel that abortion will pose a double threat to her physical health. She may experience feelings of rebellion and see herself as a victim of injustice, as I have noted with several women who have had to have an abortion after contracting German measles in the early stages of their pregnancy.

In the case of unwanted pregnancies and abortion, the man must obviously also be taken into account, since he is jointly responsible for the pregnancy. His absence, indifference, passivity, pro- or anti-abortion attitudes are all part of the clinical picture and often have a determining influence of the woman's decision.

#### Teen-age Abortions

At the Notre-Dame hospital, more than a third of the therapeutic abortions are performed on teen-agers from 13 to 17 years of age-- in most cases for psychosocial reasons, since strictly psychiatric

considerations are rare. The following kinds of behaviour and personality traits are found in most teen-agers who request therapeutic abortions:

--The girls use of sexuality for reasons other than pleasure (that is, to get love, to create ties).

--More guilt is felt about sexual relations. This guilt becomes a hindrance to the use of a satisfactory contraceptive method.

--The teen-age girl's passive behaviour toward the boy, who is seen as strong and all-knowing. If she worries about the possibility of becoming pregnant, she soon lets herself be reassured by her companion.

--The phenomenon of "magical thinking" which makes the girl think that all she has to do is not want to be pregnant to avoid getting pregnant.

--The mechanism of negation. In spite of the fact that she misses her period, the teen-ager refuses to believe that she is pregnant. This behaviour is partly responsible for abortions performed during the fourth month.

--Fear of parents' reactions. Feeling guilty, the girl is afraid of being blamed and punished, and is unable to tell her mother of her condition. The teen-ager is often the one who, on her own, takes the first steps toward having a therapeutic abortion. She hopes that everything can be fixed up without her parents' finding out. Nevertheless, she has mixed feelings about this aspect of

her problem. On the one hand, she would like her parents to know about her pregnancy (she needs them and wants to test their reactions but on the other hand, she fears losing their trust and affection. She is afraid of even greater rejection; she is afraid of being punished. With teen-agers who evidence certain behavioural problems, institutionalization has often been threatened as a punishment. The father, especially, is the one who is most feared. Many abortions are performed on teen-agers without their father's knowledge. The mother is then the one who decides to conceal her daughter's pregnancy from her husband. Since she is often more permissive than her husband, she is afraid of being blamed. It is hard for these women to go through their daughter's pregnancy alone. The social worker should thus be there to give them moral support.

Desertion by the boyfriend is generally not felt as strongly by teen-agers as by adult women. Little or no hostility is expressed toward the boy. The teen-ager feels that she alone is responsible for her pregnancy even if, intellectually, she recognizes that this responsibility should be shared. The teen-ager sees herself as a victim, and we have to watch out for masochistic behaviour which will influence her perception of herself.

In general, the teen-ager has not been given satisfactory sex education. She is not familiar with her own body; she does not know how her reproductive system works and sees it as something mysterious. The mothers, brought up in the midst of sexual taboos



and struggling with their own poorly identified and poorly accepted sexuality, are unable to discuss this subject with their daughters. In view of this kind of mother-daughter relationship, the mother is not, in my opinion, the person who is in the best position to help her daughter. She can give her information, but this is only one aspect of sexuality.

In cases of teen-age abortions, the social worker must deal with the mother as well as her daughter. The social worker must understand what the mother and daughter are experiencing, what their feelings are, and above all, must not favour one to the detriment of the other.

It is often difficult to help teen-agers with contraceptives. Some will say they do not need a contraceptive. They swear that they will not engage in any more sexual activity. The teen-agers interpret any insistence by the doctor or social worker as proof that the girls are not thought to be very respectable or responsible. Other teen-agers want to use contraceptives, but are still dependent on their mother's approval. This aspect of the abortion question is still complex. Every day, I deplore the lack of resources designed for teen-agers who, without presenting any great behavioural problems, need help to see themselves, understand themselves, accept themselves and be able to establish healthy relationships with members of the opposite sex.

## COUNSELLING FOR THERAPEUTIC ABORTION PATIENTS

Robert J. Marcus, M.S.W.

Following 1969, when a Criminal Code amendment legalized therapeutic abortions if approved by a hospital committee, the number of these procedures performed at the Vancouver General Hospital accelerated rapidly. A total of 102 therapeutic abortions were done at the hospital in 1969; in 1974 the number had risen dramatically to 3,845.<sup>1</sup> While the demand taxed the hospital's capacity, it also stimulated the development of a counselling service for patients undergoing abortions.

It took time for this service to come into being, however. Before it was initiated, public awareness of the medical criteria for therapeutic abortions was generated by the education programs and pressure of women's self-help groups. The clinics they established offered a warm approach to clients (generally younger single women) and provided information about doctors prepared to perform abortions without moral prejudice. But despite greater societal acceptance of the procedure and the increasing numbers of hospital-induced abortions, nursing staff and physicians remained apparently unaware of the importance of counselling for abortion patients.

The hospital's Department of Social Service had some experience with abortion patients in 1969 through the out-patient services of the hospital Women's Clinic, which provided gynecolo-

gical and obstetrical services, including therapeutic abortions. A social worker was, and continues to be, part of the initial documentation process of out-patient services and provides counselling services for abortion patients.

From the beginning patients seen at the Women's Clinic for abortion services were admitted as in-patients, and by 1970 they represented about 10 per cent of the 1,208 patients undergoing abortions in the hospital.

About this time both the hospital's Abortion Facility Committee and its Planning Committee recommended that a day surgery unit be opened to handle therapeutic abortions and other surgical procedures; it would be able to handle 20 such procedures a day. The hospital's Department of Social Service was involved in planning the unit, which was to open in 1973,<sup>2</sup> although by 1975 it still had not been opened.

In 1971, several staff doctors, notably the late Dr. David D.A. Claman of the Department of Obstetrics and Gynecology, and some nurses requested Social Services to extend its limited counselling of abortion patients beyond the Women's Clinic. From first-hand experience elsewhere, Dr. Claman was aware of the need for counselling patients both before and after abortion. His findings were supported by our limited experience in the Women's Clinic, where most of the women seen about abortion were young. For this group, counselling intervention would

provide an educational opportunity as well as channel to a family physician or family planning clinic for birth control information. This was deemed essential, for it was becoming clear from interview information and repeat patients that, while abortion is a desperate solution not intended in law to be used as a birth control method, the service was being used as such by many patients.

By then, the increasing numbers of abortion patients were creating a hardship on hospital operating-room facilities (requiring the rescheduling of abortions to evening off-surgery hours) and the Social Services unsuccessfully requested an additional social worker to assist with the caseload.

Social Services began to develop a proposal designed to define and provide a counselling service for all abortion patients served by the hospital. In 1972, a proposal for a one-year demonstration project, the Vancouver General Hospital Day Surgery Counselling Service, was submitted to hospital administration for approval. The objectives of the proposal were to:

1. Inform patients faced with an unplanned and/or unwanted pregnancy, of alternatives available in the community--such as adoption, foster care, day care or abortion.
2. Provide family planning information and increase the use of effective contraception.
3. Reduce stress and anxiety related to the abortion.

A service outcome proposal to assess the effectiveness of counselling in attaining two of the objectives, family planning education and patient stress reduction, was included in the proposed project. A control and experimental method was part of the design for this assessment purpose.

In April 1973, following approval of the proposal and assignment of Barbara Kaminsky M.S.W., as the project director, the proposal was presented to the Planned Parenthood Association of B.C. with a request for co-sponsorship, which was declined. In November 1973, the proposal was submitted to the Family Planning Division, Department of National Health and Welfare. The request for funding was supported by the Grant Coordinating Committee of the Planned Parenthood Association, B.C. which, however, advised against inclusion of a research component. Funding was not received until October 1974, almost a year later.

In the meantime, a few doctors who were involved with therapeutic abortions at Vancouver General Hospital requested Social Services to provide a counsellor for their abortion patients at their offices. It proved impossible to initiate such a service since provincial hospital programs' regulations do not permit staff social workers to provide services outside the hospital. It was clear, however, that counselling patients at the hospital on the day of the abortion was far too late to be effective and our experience, as well as a review of the literature,

showed that after hospitalization patients are difficult to trace and have a strong desire to avoid continued contact. We attempted to extend our services to the in-patients on gynecology and obstetric wards, but the lack of awareness by most physicians and nurses of the need for counselling became evident. Since the services of a social worker must be requisitioned, access on the wards to abortion patients who exhibited emotional problems, unfortunately, was limited.

During the summer of 1973 it was possible to employ a university student through the Provincial Student Employment Program to establish contact with medical practitioners and their patients for pre-abortion and follow-up counselling services. In September, a different counsellor was funded through the work program of the provincial Department of Human Resources; the service was continued to September 1974.

In retrospect, the experiences of those lay counsellors was valuable in our contacts not only with physicians but also in working out procedures for access to patients during hospital confinement. Considerable negotiations were required with administration and nursing staff to allow the counsellors to visit patients on the wards and to permit the counsellors to become familiar with the various abortion procedures.

With federal funding of the Day Surgery Counselling Project by the Family Planning Division, employment of a full-

time lay counsellor became possible. Advertising drew several applicants who were abortion activists and hoped to promote their cause, which was being debated through the news media at the time. The hospital administration tended to be sensitive about the controversy after experiencing several demonstrations staged by pro-life and pro-abortion groups and, consequently, advised that a low profile be maintained on the counselling service and that "no publicity about the counselling service be issued."

From October 15, 1974 to August 15, 1975, the one counsellor was in contact with 287 patients, most of them referred by only two physicians. The counsellor was invited to their offices, where she saw the patients for 30-50 minutes after they had seen their doctor. Patients who could not wait to see the counsellor were given appointments for interviews at the hospital only one block away, but they rarely kept them. Prior to abortion, patients were again seen in a hospital room next to the operating theatre. Initially a follow-up interview also was planned but, because patients tended to discontinue all contact with us after abortion, the follow-up procedure became a telephone call. The average number of days from first counselling to the last telephone call was 57 days, the lengthy case-open period resulting from the difficulty in making the follow-up contact, and the need to wait until four weeks after the therapeutic abortion to assess whether the women had seen their doctors and

begun to use contraceptives. Since 36 per cent of the women lived outside Vancouver, it was difficult to establish even telephone contact. Letters were sent to this group, but only slight response was obtained.

Patients referred to the service tended to be in the younger age group, with 37.6 per cent between 14 and 19 years of age, and 32.4 per cent between 20 and 24 years of age. Sixty-six point six per cent were single; 10.8 per cent were married; 11.5 per cent were living in common-law arrangements; and 11.1 per cent were separated, divorced or widowed. Twenty-nine point six per cent were students. Fifty-five, or 19.2 per cent, were repeat abortion patients, 15.7 per cent of these having had one previous abortion, 2.4 per cent having had two previous abortions, 0.4 per cent having had three, and 0.7 per cent having had four previous abortions. (Medical records show that the hospital repeat rate for all abortion patients is 18 per cent).

The counsellor's access to a patient at the physician's office was one of the main problems to be worked out, since the doctor-patient time averaged about 15 minutes, while counsellor-patient time averaged about 40 minutes. This often resulted in accumulation of patients in the reception area, to the annoyance of the doctor and receptionist. When the service was extended to four doctors (some of whom did not have available interviewing space) the problem became critical because of a continued heavy



failure rate with patients who were given later appointments. In an effort to solve this dilemma the counsellor experimented with group sessions for five-to-seven patients on the evening of the day after they had seen their doctors. The experiment was based on the experience of another study<sup>3</sup> which indicated that group sessions were an effective means of providing birth control information to younger people. This attempt to establish group counselling did not prove successful, however, as few patients attended the sessions; the counsellor, therefore, reverted to attempting to see as many as possible in a doctor's office, arranging later appointments for those who could not wait to see the counsellor after seeing the doctor.

Evaluative research on the effectiveness of counselling was built into the service, but since research done by one counsellor would have limited validity, the research component was postponed until funds could be obtained to introduce a second counsellor. Approval for the research part of the study was granted by the Family Planning Division, Department of Health and Welfare Canada in February 1975, making it possible to employ a second counsellor (in July 1975) and set up control and experimental group. The two groups were assessed on six main variables: 1. Use of contraceptives; 2. Knowledge of reproduction and contraceptives; 3. Consideration of alternatives to abortion; 4. Feelings about abortion; 5. Attendance

at medical follow-up appointments; 6. Number of repeat abortions.

Letters were sent to all physicians who were the major users of hospital facilities for therapeutic abortions. Some 40 doctors were contacted and requested to participate in the research project, through referral of their patients to the counsellors. Follow-up interviews with the doctors by the project director were made to explain the project, its method of operation, and the content of the counselling program. In this way, 21 doctors were recruited to participate in the program. At the same time, negotiations were undertaken with the hospital administration for referral of all abortion patients for a period of six months to ensure a representative research sample, but this approach was not acceptable on the basis that the hospital was not in a position to enforce the referral procedure. The present voluntary referral system tends to provide a sample based on the motivation of the doctor and his or her receptionist, along with the motivation of the patient to see a counsellor. As indicated earlier, most doctors are selective, tending to refer the younger, single patients.

The counsellors see referred patients for approximately one hour and fifteen minutes. The first interview in the doctor's office lasts 40 minutes and, because of scheduling in the operating room, the counsellor sees a patient about 20 minutes prior to her abortion. The follow-up interview on the telephone generally

lasts 15 minutes. In view of the short time available, the content of the counsellor's interview is regularly revised. Some of the main points covered by the counsellor are knowledge of reproduction and methods of contraception, their relative effectiveness and possible side effects. A variety of birth control pamphlets are given to all women who receive counselling and the diagrams are used to emphasize aspects of reproduction and contraception. The counsellors tune into the patients' feelings and attitudes and present the information accordingly.

During the first counselling session, consideration of alternatives to abortion are discussed in an effort to establish that the patient is aware of other ways of dealing with her unwanted pregnancy and gives reasonable consideration to them. An attempt is made to persuade the patient to use reliable methods of contraception following her abortion. (During the first phase of the project, five of the 287 patients decided after counselling to go through with pregnancy and two cancelled their planned abortions.)

Counselling sessions include explanations about the abortion process (including hospital procedures) and the patient's attitude to abortion, with a view to minimizing any negative feelings such as anxiety, anger or fear. The physical presence of the counsellor immediately prior to the abortion seems helpful in easing the patient's anxiety. The counsellor emphasizes the need

for medical follow-up, which usually is booked two-to-four weeks after the abortion. It is sometimes necessary to motivate patients to keep the follow-up appointment by alerting them to medical complications that could arise. These counselling components are considered as reference points that the counsellor keeps in mind, altering the emphasis according to the needs of the individual. While two face-to-face contacts are considered minimal for all women in the counselling group, more are arranged for patients who require additional assistance.

The effectiveness of the counselling process will be evaluated through a self-administered questionnaire to be completed by the patients two weeks prior to abortion, five weeks after the abortion, and six months after the abortion. The results of the evaluative research will be published when the project is completed in 1976.

Some preliminary observations regarding our attempts to establish counselling as part of the hospital therapeutic abortion services are as follows:

1. The number of repeat abortions is creating pressure on the hospital and doctors to evaluate their present procedures. There is concern that abortion is being used as a method of birth control per se, rather than as a compensation for contraception failure.
2. Counselling the abortion patient is not fully accepted by most doctors. Acceptance will require establishment of research data that support its value.

3. The repeat abortion rate also raises questions about the doctor-patient form of learning birth control practice. There are practical problems in communication between a busy doctor and a woman with an inadequate sexual education. The situation is further complicated by widely differing medical, psychological, moral and religious views on conception, and the sexual attitudes of the medical and nursing professions. Research may answer the question as to whether a counsellor and a doctor are more effective as a team in teaching contraception to patients than a doctor is when acting alone.

4. Discussion of birth control methods is an important part of the counselling service and some women require factual information to change their contraceptive practices. In the sample of 287 patients, 56.1 per cent had used oral contraceptives prior to conception, 20.6 per cent used other methods and 23.3 per cent used no methods. At the time of conception in the same sample, 5.6 per cent were using oral contraceptives, 43.5 per cent were using other methods and 50.9 per cent were using no birth-control methods. After the abortion, 35.9 per cent were on oral contraceptives, 17.4 per cent were on other methods and 1.4 per cent used no method. (In this group 45.3 per cent were unavailable to indicate what methods they were using.) Patients who used oral contraceptives prior to conception, but who had discontinued the oral method when they conceived, provided an

interesting variety of explanations for being "off the pill." The most common reason was physical discomfort from unanticipated side effects. Other reasons were anxiety caused by doubts about the long-range effects of oral contraceptives and vague feelings that use of oral contraceptives is against nature. After their abortions, however, a good percentage of the women resumed taking oral contraceptives.

5. In a program of this kind, assuring a counsellor's access to and time with patients is a difficult management problem requiring cooperation of the doctor, receptionist, hospital administrative staff and the patient. This cooperation is dependent on the attitude and motivation of all involved. There appears to be some agreement by physicians that the younger patient could benefit from counselling.

Data from research being done by the hospital's Department of Social Service should clarify the social worker's role by defining counselling for abortion patients and identifying high-risk groups with whom counselling is effective. It is hoped that this research project--the only one of its kind in Canada--will encourage and assist other hospitals to undertake and/or extend an abortion counselling service that will help to educate and motivate patients to use more rational means of birth control.

# FOOTNOTES

<sup>1</sup>Vancouver General Hospital, Medical Records Annual Therapeutic Abortions.

1969 - 102	1972 - 3,145
1970 - 1,207	1973 - 3,413
1971 - 2,953	1974 - 3,845

<sup>2</sup>Vancouver General Hospital Program, Day Care Surgery Unit Report, May 1973.

<sup>3</sup>Bracken et al. "Abortion Counselling: An Experimental Study of Three Techniques," American Journal Obstetrics & Gynecology 117 (10) (September 1973): 10-19.

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## FAMILY PLANNING AND MENTAL HEALTH

Glenn S. Rutherford, M.S.W.

The term "family planning" is frequently used in numerous contexts to refer to various activities. For some it refers specifically to the use of a method or methods of conception control. At the same time others use it in a much broader context to refer to activities ranging from the use of a conception control agent to the inclusion of abortion and yet further to include the long-term processes through which many couples go to plan their families. Too often, family planning is used synonymously with techniques of conception control. Needless to say, this greatly over-simplifies the issue and gives no account to the inter-personal processes through which individuals and couples work in determining the make-up of their families. McCalister, Thiessen, and McDermott, recognize the complexity of the family planning process. They define family planning as "the intricate process by which persons, if they wish, can determine for themselves the timing, spacing, and number of children to be born to them."<sup>1</sup> Although the "intricate process" to which they refer is not clearly defined, its interpretation may well include the development of personal, ideological, and affective components which occurs long before a person adopts or even considers adopting the use of a conception control technique

and which may well predispose the person to certain family planning practices. The volume of research relating early development to family planning practices is extremely limited and thus precludes drawing generalizations which might be used as a basis for developing extensive family planning services.

Returning to McCalister's definition of family planning, I would restate the definition to read: "Family planning is the intricate process by which persons, if they wish, can determine for themselves the timing, spacing, and number of children they choose to rear." This definition expands the concept to include family situations in which children are adopted, either formally or informally. This definition also includes those who choose to have no children.

As difficult as it is to define the limits within which to manage family planning, "mental health" is even more unmanageable. More often than not a state of pathology, mental illness, is defined and mental health is taken to be the converse state. However, the United Nations definitive statement on health affirms that it is not merely the absence of disease or infirmity, but something more. But what is that something more? The question remains unanswered because both mental illness and mental health are generally interpreted as culturally relative terms. Therefore mental health, or the degree thereof, is that condition of a person's functioning which results from the

complex interaction of what he thinks, feels, and does. Again, this is considered relative to the social milieu within which the individual finds himself. For example, a condition that in one society is considered to be a pathological state, or illness, may be paralleled in another by a religious rite or ritual. Therefore we have no universally accepted behavioural definition of mental health.

Although family planning and mental health appear at first to be quite unrelated, there are several characteristics common to both. First, in both cases the biological, psychological, and social aspects of life must be considered as affecting and being affected by human behaviour. Professionals must be aware of the complex interrelationship of these variables.

Second, as the complexity of the relationship of these variables within each field has become appreciated, multidisciplinary teams have evolved to deliver the respective services. No one discipline has mastered all the skills required to manage adequately all dimensions of either field.

Third, one of the objectives of professionals in each field is to enable the individuals with whom they work to develop their individual potentials and means of expressing them in ways that do not violate the freedom of others.

Fourth, in relation to both fields the individual is

perceived in a social context. Most frequently his behaviour affects and is affected by those around him.

Given these common characteristics there would logically seem to be a close relationship between an individual's family planning practices and his state of mental health. One might postulate that as a person's mental health deteriorates his effectiveness in making sound decisions and demonstrating effective measures of family planning will also deteriorate. The opposite is possible as well. Limited research has been done on the bio-psycho-social characteristics of users of birth control methods in an attempt to determine what variables might be considered when trying to predict the patterns of family planning practice that individuals will follow.<sup>2</sup> As yet only broad categorical definitions have served any useful purpose in this regard. For example, ethnic origin, social class and religion, have been used as predictors of the utilization of conception control methods. If the hypotheses as stated, postulating a direct relationship between the level of mental health and effectiveness of family planning practice, cannot be statistically supported, we must rely on research findings of more limited scope and on the experience of family planning and mental health fields practice.

#### Development of Family Planning Services

Although specialized family planning services offered through

various public and private health care systems have increased in both quantity and quality since 1969, they remain far short of being adequate to meet the public need. Many factors have contributed to the slow development of these services. A few of the more obvious include: the relatively recent legalization of the dissemination of conception control information, the lack of adequately trained manpower, the enduring controversy around some aspects of family planning and the increasing health care costs. Family planning services are offered by many of the medical profession through hospital out-patient clinics (a total of 19 in January, 1972) and student health services clinics (11), private organizations supporting clinics and home visiting programs (16), and the public health system (25).<sup>3</sup> Unfortunately the kind and quality of services vary significantly from one source to another. The extent to which they are standardized appears to be most closely related to the extent to which services are affiliated under the same administration or program direction.

Despite the movement by various levels of government, educational institutions, and private organizations to develop family planning resources, it appears that there will not be adequate specialized family planning services in the immediate future. As an alternative, it seems most feasible that other service systems will become involved (in fact they already are) in the delivery of some family planning services. Mental health

facilities are an alternate resource for some of these services.

### Evolution of Mental Health Services

In the past decade the nature of mental health services has changed significantly and continues to do so. Whereas until the early 1960's the emphasis of mental health (or more appropriately mental illness) programs was on institutional care, in the last decade a significant swing has occurred toward providing services to a large segment of the population that has never been admitted to an institution. However, as one aspect of this evolution some of the most dramatic practices related to family planning have occurred in the last few years in institutions for the emotionally disturbed and handicapped. For example, it was only until the beginning of the last decade that many institutions routinely sterilized the chronic severely emotionally disturbed and/or mentally retarded if institution staff felt that these in-patients might show the least interest in reproduction. In the past similar and even more severe practices have been used on sexual offenders. Although the practice has become uncommon, it was only within the last few years that the legislation enabling these practices has been revoked in several Canadian provinces.

The development of community mental health services has brought with it the demand for the involvement of mental health professionals in a wide variety of situations. With

increasing frequency the various disciplines in the field of mental health are being called upon to meet needs of psychosocial development and needs related to interpersonal relationships. Many of the functions they now perform do relate closely to services offered through family planning clinics.

#### Mental Health and Family Planning

In attempting to fit the practice of mental health social workers into the context of family planning services, it would be impossible, in this short space, to address the many circumstances to which they can make a significant contribution. Thus the following is a brief outline of some of the functions and tasks that they might most appropriately perform.

The general function of a social worker in the field of mental health is to assist a client or client group to realize a sense of congruence (in what he thinks, feels and does) within and with his environment. With this definition of function, and the earlier definition of family planning -- the intricate process by which persons can, if they wish, determine for themselves the timing, spacing and number of children they choose to rear -- the tasks and functions that are to follow seem to be reasonable expectations of social workers practising in the field of mental health and dealing with matters relating to family planning.

### Description and Information

Social workers deal with many situations that involve vague and sometimes confusing information. Often it is not clear if there is a request for service and, if there is; for what. Much of this apparent indecision on the client's part often results from anxiety created by having to seek assistance, not to mention anxiety aroused by the initial circumstances. The social worker in this case can assist in decreasing the level of anxiety and increasing the client's potential for managing the situation and helping to clarify the description of circumstances, define more clearly the request for service (if one is, in fact being made) and give information regarding the specific situation or other resources which could be explored in relation to it.

For example, a 16 year-old girl referred to me by her high school counsellor had been an excellent student academically and was active in many school activities with many friends. Suddenly her marks deteriorated and her involvement in activities dropped off. Her parents had become very concerned. "Shelley just isn't herself any more," her mother told me. The school counsellor couldn't explain this sudden change. Shelley's parents were not able to account for it, and in fact Shelley wasn't sure what had happened. After discussing the situation with Shelley and her parents it turned out that Shelley's boy



friend wanted to have sexual intercourse with her. She had mixed feelings about it and was afraid. Through discussions with Shelley, her parents and the counsellor about her circumstances, a clear picture of the situation was reflected to her. As it turned out the school's requests, similar to those of Shelley's parents, were to improve her academic performance and reinstate her in her former activities -- neither of which could be effected either instantaneously or directly. Shelley's requests, on the other hand, could be responded to immediately. She wanted and received information about sexual behaviour of other adolescents her age and about conception control methods; she felt this would help her sort out her thoughts on the situation. The suggestion was made that she might pursue the conception control interest with her family doctor. Also she wanted support to talk to her boy friend and her parents about the situation; she received it over a period of several weeks.

#### Management of Emotions and Relationship

It was necessary to help Shelley explore her feelings about many things related to the circumstances in which she found herself -- her boy friend, her parents and their expectations of her, her dreams for the future and so on. This not only made her more aware of what her feelings were but also helped her realize what some of the push-pull forces were that gave her the "mixed

feeling" sensation and the fear. She later told me how, throughout our discussions, she came to feel more comfortable discussing her feelings regarding her circumstances with her boy friend and her parents. This in turn enabled her to take a knowledgeable stand with which she felt comfortable and which she could communicate to those close to her.

The functions referred to here are 1) assisting with the exploration of feelings, 2) development of confidence and communication skills to facilitate a sharing process with the significant others, and 3) by assisting with the above, facilitating a knowledgeable decision-making process.

Throughout the counselling sessions with Shelley, her parents and her boy friend, it was necessary to consider the economic, cultural, religious, and social conditions affecting the situation. The influence which each played on her behaviour was significant.

The functions listed to this point have required simple, basic clinical social work skill. They are not unique to social work in the mental health field, nor are they utilized only in relation to family planning issues. They are mentioned in order to illustrate the skills that social workers practicing in the mental health field can generally contribute to the family planning service.

### Shaping of Services

As specialized services are made available to meet specific family planning needs, social work practitioners refer clients upon request or perceived need to such other resources. For example, referrals are frequently made from mental health services to general practitioners and family planning clinics for more specialized conception control information.

In some circumstances social workers act as advocates for clients by representing the interests of their clients to other service agencies. For instance, representation was made on Shelley's behalf to the school system to enable her to continue in her established class routine. The school counsellor and principal felt that with Shelley's deteriorating grades she would not be able to handle a full work load. On the contrary, Shelley felt that she would be able to maintain the work load she had established and acquire credit for her classes.

Social workers also often stimulate action in the forms of change in existing structures or development of new services resources. Through the exercise of dynamic leadership, interested individuals may be organized to form new resource bodies or augment existing systems. In another situation, a social worker who worked with a public health nurse in a common geographic area was able to offer the nurse suggestions that resulted in modifying prenatal classes she led; the nurse increasingly involved

husbands of the expectant wives who had shown interest in the sessions.

On the basis of clinical and other experiences related to family planning, it is evident that social workers possess individual and collective talents that can be mobilized to lead the drive for legislation and policy reform aimed at improving the quantity and quality of family planning services and ultimately at improving the quality of life to be enjoyed by all within their community. Such reforms might include the introduction of family planning services into public health care systems, the inclusion in medical care insurance programs of the costs of all family planning services, and municipal and provincial funding for the establishment of specialized family planning clinics.

#### Manpower Development

With the shortage of specialized family planning services and trained manpower referred to earlier, it is inevitable that more time, money and people are needed to augment the existing resources for family planning services. Three obvious options are worth considering. The first is to train more people to staff additional specialized family planning clinics. The second option is to train other agencies' personnel with some basic family planning knowledge and skills; referrals might then be made to these professionals or they could be seconded

to family planning clinics. The third option is to do both of these: train some "specialists" and other agencies' personnel. The latter is the most desirable alternative. People are coming to mental health clinics in increasing numbers for services of a family planning nature. Since they often do not identify their concern as such, the practitioner needs to know enough about family planning to enable him to detect the problem and help identify the request for service.

For any of these three options to be followed in the development of family planning services there is an obvious need to train both professionals and volunteers. Professional schools of social work have not made great contributions to the development of family planning services. A relevant curriculum must be generated and field experience encouraged in the family planning context.

### Conclusion

Inasmuch as family planning is a process affecting what one thinks, feels, and does, it is a vital concern of social workers in the field of mental health. After all, something all of us have in common is that we have all shared at least once in that "intricate process" (if not as the decision makers, then as the one about whom decisions were or were not consciously and knowledgeably made). Again I suggest that as individuals

experience a state of mental health, they will most successfully encounter the intricate process of family planning. Within this context it is reasonable to expect that social workers in the field of mental health will pursue aggressively tasks and functions they can capably perform to meet emotional needs and allay the fears associated with family planning.

#### FOOTNOTES

<sup>1</sup>Donald V. McCalister et al, "Introduction to Part I" in Donald V. McCalister, Victor Thiessen, and Margaret McDermott, eds., Readings in Family Planning: a Challenge to the Health Professions (St. Louis: C.V. Mosby Co.,1973) p. 1.

<sup>2</sup>Donald V. McCalister and Victor Thiessen, "Prediction in Family Planning: prediction of the adoption and continued use of contraception," *ibid.*, p. 153.

<sup>3</sup>Canada, Department of National Health and Welfare, The Current Status of Family Planning in Canada (Ottawa, 1973) p. 24. (The numbers in parenthesis indicate the numbers of identified family planning clinics of various types in Canada, January, 1972. Eight "others" were also verified.)

## SEXUAL BEHAVIOUR: RIGHTS AND RESPONSIBILITIES--

### An Educational Proposal for Mentally Retarded Persons

Rena Paul, D.S.W.

Historically, social workers have always been interested in the congruence between the inner psychological realities of man and the social context in which he lives. The aim of casework is the rebuilding, strengthening or modifying of response patterns of persons who are unsuccessful in their person-in-situation (that is person-to-person or person-to-circumstances-transactions). Casework itself is a problem-solving process designed to aid a social work client attain a more rewarding psychosocial adaptation.

My work experience showed me that no matter what a client's problem and no matter what the specific function of the agency, sexuality invariably appeared as an important component of the total situation. Yet, nothing in my own professional preparation for social work, or in my undergraduate training in psychology prepared me for coping with the sexual lives of my clients. My efforts as a social worker reflected the inadequacy of my training. I lacked basic information about human sexuality, as well as skills for using such knowledge. No wonder my effectiveness was reduced. To be sure, in our courses on human development we did talk about sex of sorts, but it was never sexuality of health and joy. The thing we discussed--and even



that in moderation only--was sexual expression distorted by neurotic twists and twinges. Healthy, lusty, untimorous sex was never mentioned, or at least not in my presence. It is to be hoped that the current generation of social work students receive the benefit of a less timid curriculum, and that courses on human development provide a more complete and realistic knowledge base, encompassing more than just family planning and providing opportunities for students to learn about all aspects of human sexuality.

When I began working with the mentally retarded, with emphasis on facilitating their absorption into the community, I became aware of additional dimensions of human sexuality and most particularly of the power of social control and social sanction when applied to the dependent, deviant individual. Participation in the outside world necessitated preparation of the client himself, his parents and the surrounding community. It required teaching the mentally retarded person social skills that would make him comfortable with others and allow others to accept him. Of particular relevance to this discussion is the extent to which sex, sex education, and sexual expression entered all phases of our program and how it forced all of us involved in the program to re-examine our values<sup>1</sup> regarding sex, and our commitment, public as well as private, to what we considered important and valuable.

It quickly became apparent that human sexuality and sex education could not be discussed outside an ethical framework. The interpretation of human sexuality is always moulded by the personal values, convictions and idiosyncrasies of the instructor. It is the instructor's personal philosophy that determines the kind of sex education his pupils receive.

In one view, knowledge is necessary to guard against risks inherent in all sexual practices. Understanding provides a means of control of all sexual activity. Thus, knowledge so acquired becomes a deterring bulwark against proscribed sexual behaviour. Another view is that knowledge--including knowledge of human sexuality--should be used to enhance our appreciation and enjoyment of life. The purpose of instruction is always an enabling one. Teaching is for use, for application of facts learned, for the dispelling of misinformation and for the expansion of physical and spiritual horizons.

My own orientation approximates closely the second point of view. I think that sex is joy--and comfort-giving. It represents a powerful need, though the intensity of it varies from individual to individual and, depending on time, place and circumstances, within the same individual. All persons need and want to express their sexuality. The expression of sexual strivings is an inalienable human right.

Within its formulation, sex education encompasses more

than the anatomy and physiology of procreation. Knowledge of our bodies, instruction on family planning and the awareness of social and psychological expectations must be combined with a reinterpretation of "normality" and techniques for sexual enhancement, be it in coitus or in self-pleasuring. One cannot, however, insist upon the universal ability to exercise a right without acknowledging the concomitant responsibilities. The right to sexual activity cannot be separated from obligations inherent in the right. My values dictate the following responsibilities and obligations:

1. Overt sexual behaviour must be exercised with regard to social usages and conventions.
2. Sexual activity should take place only when both partners understand and accept the nature of their relationship.
3. Since sexual activity leads to procreation, it is the responsibility of the participants to control conception.
4. Participants have an obligation to ensure sexual satisfaction of their partners as well as themselves.
5. Any specific sexual activity must be acceptable to both partners.

After all, people are not created physically and spiritually alike, and the need to respect differences increases

inversely in ratio to the intimacies shared.

#### Sexuality and Mentally Retarded Persons

Is all this relevant to the mentally retarded? There seems to persist an erroneous notion that the sexuality of the identifiably different is, ipso facto, also different. And there is no doubt that the majority of the retarded are visibly different from the majority of the rest of the population. Does this perceived difference imply a difference in their eroticism as well?

The mentally retarded are human beings with an impaired ability to function independently. With the exception of the small minority comprised of individuals who are very severely affected physically and intellectually and who indicate a minimal ability to communicate, the condition of mental retardation by itself in no way negates or diminishes the person's sexuality. Nor does it affect his right to express sexuality in a socially responsible manner. However, for the mentally retarded social responsibility should include one constraint: non-parenthood.<sup>2</sup>

In sex education courses designed for the average consumer the actual application of contraceptive techniques is left to each individual's discretion. With the mentally retarded person, contraception and avoidance of parenthood must be considered non-discretionary. After all, persons unable to care for themselves should not be required to assume responsibility for dependent others.

Discouragement of parenthood is of vital importance and deserves special emphasis in any training program for the retarded. Ideally, such training should begin in the nursery school where traditional male-female roles and expectations of parenthood can be de-emphasized. Both sexes should be given equal time with dolls and trucks. Girls do not have to keep house and babysit and boys need not concentrate exclusively on traditional male roles. It helps greatly if this trend continues through school, with suitable reinforcement and support from home. With increasing chronological age, the same principles can be built into personal and career planning. Not every adult individual marries, and not all couples have a family. A realistic exposure of the retarded to the demands of child care through participation in the daily routines of younger children is most helpful in dispelling fanciful notions and reinforcing the advantages of non-parenthood.

With the single difference of emphasis on non-procreation, the material content of a program on human sexuality is essentially the same for all, although the amount of detail presented will vary depending on the students' levels of comprehension.

Material to be Included in a Course on Human Sexuality for the Mentally Retarded:

1. Getting to know one's body

- Functional anatomy;
- Positive interpretation of individual differences - size of breasts, sex organs, circumscised and non-circumscised penis;

- Menstruation;
- Nocturnal emissions;
- Conception;
- Contraception;
- Birth.

## 2. How to take care of one's body

### a. Health

- Symptoms of venereal disease;
- Prevention of venereal disease;
- Need for regular medical care;
- Need for regular dental care.

### b. Hygiene

- Personal cleanliness;
- Washing and bathing;
- Hygiene of elimination;
- Shaving for men and women;
- Use of deodorants;
- Care of hair, finger and toes nails;
- Care of teeth and mouth;
- Use of cosmetics and perfumes.

## 3. Sex is fun with responsibility

- Erogenous zones;
- The pleasures of touching, self-pleasuring/  
masturbation; how (physical technique) and where  
(socially; appropriate location);

- The pleasure of touching others, how (physical technique) and where (socially; appropriate location);
- The pleasure of being touched, how (physical technique) and where (socially; appropriate location);
- Explanation and illustration of heterosexual activity, homosexual activity;
- Meaning of bi-sexuality;
- Sharing pleasure in love making--coital enhancement;
- Receiving and giving pleasure--pleasuring of partner and of self.

#### 4. Prevention of parenthood

- Responsibility of parenthood;
- Parenthood is not for all;
- How to avoid parenthood;
- The advantages of being single and unencumbered;
- The advantages of non-parenthood.

#### 5. Obligation toward sexual partners

- Prevention of pregnancy;
- Protection from venereal disease;
- Giving pleasure;
- Affection;
- Consideration;
- Discretion in talk with others;
- Discretion in the choice of location.

### Organization of Material

The preceding list is recommended for inclusion in a course on sexuality for the mentally retarded. Please note that the list refers to the material to be taught only, and not to the actual method of presentation.

The mentally retarded show deficiencies in their potential for learning, reasoning and comprehension. They have difficulty with abstract thinking, generalizations and deductions. An effective course on human sexuality for the mentally retarded should, therefore, allow for all possible compensations to minimize these difficulties. This applies to the extensiveness of material chosen for study as well as to method of presentation. Whenever possible, instruction should be augmented and reinforced by life-like visual presentation. Diagrams and sectional representations of people as well as material based on flora or the animal kingdom is useless. It tends only to confuse and bewilder the student.<sup>3</sup>

For clarity and reinforcement, each particular point must be presented in conjunction with several relevant items and in the form of a separate lesson. In organizing material for actual presentation, the following four-pronged approach has been found especially helpful:

1. Definition and Vocabulary

This refers to the functional description of the



subject to be presented, and reviews the correct language and the vernaculars understood by the group.

2. Fears and Misconceptions

This, or course, is extremely important since very often it is the fear induced by misconceptions that militates against obtaining emotional gratification from perfectly normal activities.

3. Health and Hygiene

The need for this category is self-evident. It should be stressed that positive enhancement techniques should be combined with all negative proscriptions. For example: "Your body must be clean and sweet smelling at all times. You would not want to kiss a person whose body was not clean and nice smelling. It is very pleasant to kiss a clean person all over his/her body. Most people enjoy kissing and being kissed all over the body."

4. Expectations: Personal Responsibilities and Social Customs

These again are important, since they are designed to aid the mentally retarded person to understand and assume responsibilities expected of all adult citizens.

The following guide illustrates the actual preparation of material on nocturnal emissions with special emphasis on the educational requirements of the participants.

#### Presentation of Material

Having demonstrated the application of the four-pronged approach to the organization of material to be taught, we now turn to the actual lesson on nocturnal emissions based on the previous guide.

#### The Actual Lesson on Wet Dreams

A wet dream is when semen (a white, sticky stuff) comes out of the penis (cock, dick, dink, etc.) of a sleeping man or boy. Other words for wet dreams are nocturnal emissions and seminal emissions. (These expressions are difficult and it is not necessary for your students to memorize them.)

From time to time, all growing boys and all grown men have wet dreams. Wet dreams are okay. They tell a person that he is growing up or is already grown.

Sometimes one has a wet dream, when dreaming of pleasant or exciting things such as girls, going out, or having sex. Sometimes a person wakes up when having a wet dream and sometimes not. Whichever way a wet dream happens, it is okay.

Wet dream is not the same as bed wetting. Semen (the white, sticky stuff) is not the same as urine (pee, piss, number one, etc.). A person cannot stop having wet dreams.

# GUIDE FOR ORGANIZING MATERIAL

## NOCTURNAL EMISSIONS

Definition and Vocabulary	Fears and Misconceptions	Health and/or Hygiene	Expectations: Personal responsibilities and social customs
Seminal Emission	It is not urine. Not related to enuresis.	Maintains acceptable cleanliness by daily bathing.	
Nocturnal Emission (Wet Dream)	It is not bad or sinful. Has no connection with bad thoughts.	Change of bed linen.	The concept of "private and personal" as it applies to seminal emissions.
Body expels excess semen. Characteristic of all pubescent and adult males.	It is not a sign of illness.	Change of personal linen.	Responsibility for observing social customs like privacy and cleanliness.
Sign of maturation/or maturity and as such to be welcomed. Can be connected with erotic dreams.	Amount of semen expelled it is not related to size of penis or body. The occasional pleasurable association is normal.	Usage of different linen for night and day. Above must be relevant to living conditions of a student.	

Semen often makes a spot on your pyjamas or bed sheets. (Do not use the word stain since it has negative implications.) How much semen comes out, and how big a spot it makes has nothing to do with the size of the penis or the size of his body.

You must remember that when a semen spot (the white, sticky stuff) gets dry, it develops a strong semen smell. The strong smell of dry semen is not nice to others. For this reason, you should always wear pyjamas at night, (or name whatever is worn), and underwear during the day. This means that every morning you get on your underwear and every evening you put on your pyjamas.

In the same way, you must take care of your body. Because semen gets all over your body, it is important to wash your body at least once every day. Remember, you must be clean and sweet smelling all the time.

Another thing which is important to remember is the word private. We talked about private and privacy before. Who can tell me what private means?..... (for me only). Who can tell me what privacy means?..... (to be by myself). Good. Very good. Now, who can tell me what it means to keep wet dreams private. That is very good. Yes,..... is right. We do not talk about wet dreams to strangers. Most of the time we keep it to ourselves. Sometimes we talk about wet dreams to persons we know well. Persons we feel very close to.

## Teaching Techniques in the Lesson

As you have undoubtedly noticed, the actual lesson employs several important teaching techniques:

1. Functional Information

Those with learning difficulties and limited exposure to other sources of information need explicit explanations. It is our responsibility to ensure that the mentally retarded possess adequate, practical information.

2. Repetition

Necessary terms should be repeated several times. The teacher or parent who feels uncomfortable with the vocabulary or with the need of repetition may well convey this attitude to the retarded person.

3. No Euphemisms

Physical descriptions must be explicit to convey information. Attempts to preserve the sensibilities of a teacher or parent by using euphemisms are usually done at the expense of comprehension by the retarded person. However, words should be chosen carefully always emphasizing the positive, i.e., Do not use "stain" if "spot" will do.

4. Acceptance of Sexuality

Words that convey the joy and pleasure of the human

body and sexuality are used to express the feeling that sex is good and to be valued. This includes implicitly and explicitly the value in both giving and receiving pleasure. Valuing a partner's needs and feelings are acknowledged as an important part of sexual contacts.<sup>4</sup> I am stressing this point since the subject matter does not permit a clear demonstration of this principle.

As has been already indicated, teaching for application represents one of my central values and the raison d'être for this paper. How then does one go about implementing sex education and, in institutional settings, providing the actual freedom to engage in overt sexual activities.

#### Strategies of Implementation

At every crossway -  
On the road that leads to  
The future  
Each progressive spirit  
Is opposed by  
A thousand men appointed  
To guard the pass  
- Maurice Maeterlinck

The person who undertakes the role of facilitator will need a great deal of patience and the courage of his convictions

to sustain him through the inevitable period of adjustment.

The following is an outline of implementation strategies found useful in a variety of settings:

1. When introducing new ideas it is useful to base one's arguments on rational considerations. Emotion enhances the conviction with which one speaks, but itself it only provides a weak rationale.

2. Sexual behaviour is not an entity in itself but a part of an overall life style. One cannot plan a "normal" sex life for people whose lives are not "normal." In other words, before we can hope for a more equitable sex life for the mentally retarded, their total life style must be normalized.

In institutions, the conception of privacy must be redefined. Privacy must be allowed in places associated with privacy within the community. Infringements on social sensibilities which constitute infringements only in institutions had better be ignored.

3. Every effort should be made to change the image of the retarded by changing their surroundings, their appearance and their skills. Modification of surroundings is particularly urgent in large institutions. Large dormitories should be subdivided into

individual cubicles and so-called living rooms be arranged to resemble real family rooms.

Mingling of sexes should be facilitated and all unnecessary inspections and control cease. Contraception should be easily available to all who wish it.

For maximum effectiveness, self-care skills must be reinterpreted to encompass aesthetic as well as practical considerations. Self-care skills must include instruction in makeup, colour blending and fashion. It is vital for the mentally retarded to learn acceptable table manners and general deportment social conventions such as appropriate greeting, entering and leaving a room, meeting and parting from strangers, modes of address. All these enhance or detract from a person's social acceptability.

4. One should not be afraid to make realistic demands upon the retarded. Unnecessary permissiveness and indulgence does not lead to successful rehabilitation.
5. It is helpful to put oneself in the position of the institutionalized and non-institutionalized mentally retarded. What are their lives actually like? What are their day-to-day experiences? Which are the most privacy-prohibiting practices, rules and customs?



Change should be initiated very slowly and carefully starting with the easiest items, where positive outcome is practically assured.

6. To change attitudes, start by exposure to new ideas. Conferences and seminars are excellent vehicles for exposure to new material. When conferences are organized, it is more productive to have "outsiders" to the system present the most controversial ideas. This way anger and disapproval is channelled away from the facilitator, who can go on challenging obsolescent practices and philosophies.

Staff committees on curriculum planning and curriculum implementation provide an excellent vehicle for dissemination of new information. Such committees can inaugurate refresher courses for long-term employees and orientation programs for new. The same group can maintain a close working relationship with local educational authorities (community colleges, universities, etc.) to encourage and exchange ideas and curriculum planning for students in mental retardation courses and staff working with the mentally retarded. The establishment of well-stocked, easily accessible libraries is, of course, a must.

7. Dialogues with staff are most productive when they involve simultaneously the highest and the lowest echelons of the administrative hierarchy. The middle usually follows the lead and presents relatively fewer problems.

In this connection, one should not neglect the unofficial or hidden pockets of power. These exist in every organization and it is not wise to ignore them or their influence.

8. Change is difficult. Some staff members will not be able to actively participate in a new curriculum or implement a philosophy based on alien concepts. One should not antagonize such people. We must allow for habits of a lifetime. If nothing else works, and as a last resort, one can use one's influence to have such staff transferred to positions where their personalities and job responsibilities infringe as little as possible on the lives of the residents.

It seems to me that the problems of the retarded were well summed up by Sondra Diamond an American psychologist and guest speaker at the Twenty-Eighth Annual Conference of the Ontario Federation for the Cerebral Palsied held October 3-5, 1975 in Ottawa. In her "Bill of Rights for the Disabled," she

said: "The universality of man is such that all people are not created physically [or intellectually] equal, but we are created equal in our needs to live a full and meaningful life and in our right to pursue it."

Surely sexual freedom is basic in this concept of equality.

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## SEXUALITY AND THE AGED IN CANADA

Benjamin Schlesinger, B.A., M.S.W., Ph.D.

Despite the substantial portion of older people in Canada, little is heard about the sexual needs of this age group.

Every medical study conducted during recent years indicates, however, that there is no physiological reason why older men and women in reasonably good health should not have an active and satisfying sex life. Yet despite increasing scientific evidence to the contrary, our culture continues to foster the belief that by the time one is in his or her sixties, sex is neither necessary nor possible; or if it does occur, it is somehow not quite normal, and certainly not nice.

Some older people fear the ridicule or censure of younger people if they show signs of still being interested in sex. Children and even grandchildren may disapprove of the sexuality of their aged relations and make them feel guilty. Yet young people do not have a monopoly on sexuality; it is with you all your life.

The 1971 Census of Canada showed that 8 per cent of our total population of 21,568,310 people were more than 65 years old (a total of 1,744,405 persons--781,865 men and 962,540 women). Older women outnumber older men because they

not only have a longer life expectancy (77.3 years as opposed to 71.4 years for men) but also because they are usually younger than their husbands.

As well as having more possible marriage partners to choose from, older men have more opportunity to satisfy sexual needs because nonmarital sex is more available to them than to older women. For older men, the fact that they grew up when "illicit" sex was a serious transgression (and therefore the idea of nonmarital relationships is not easy to accept) is somewhat balanced by the fact that they were also raised with the double standard, permitting greater sexual freedom to men. An older man can therefore purchase sex without the same fear of social disapproval that such action would create for an older woman.

The three most significant studies of geriatric sexual behaviour have been made by Alfred A. Kinsey and his associates at Indiana University, the Center for the Study of Aging at Duke University at Durham, North Carolina and William H. Masters, Director and Virginia E. Johnson, Assistant Director at the Human Reproductive Biology Research Foundation at St. Louis. In each, the findings clearly show that men and women in a state of general good health are physiologically able to have a satisfying sex life well into their seventies, eighties and beyond. The studies also indicate that those who were most active sexually during youth and middle age usually retain their



vigor and interest longer into old age.

For generations sex has been linked with reproduction in religious and cultural settings and for economic and political reasons.<sup>1</sup> Thus it followed that involvement in sexual activity ended with the menopause, when reproductive capacity ends. However, the ability to enjoy sexual relations continues well past menopause; for some people it continues into their ninth decade of life. But then, sexual enjoyment may be derived through other than actual sexual intercourse.

They treat each other with the dignity and courtesy of a blossoming courtship. At night they go to bed and hold each other throughout the night even though they have not exercised their genitalia for years. The elderly gentleman has described their experience as having a ten-hour orgasm every night.<sup>2</sup>

This is a qualitative refinement of sex rarely achieved by the young who must continually prove through performing. Like the young, the elderly also prove themselves by performing the sex act but age brings a balance of sexual quantity and quality. Ironically, the quality and finesse that young swingers and playboys seek as the "fountain of youth" comes with increased natural ease in old age, when sex is supposed to be dead!

The task today is to break through myths, taboos and misconceptions to give recognition to the reality, the beauty, the problems and the pains of sex in the later years so that we can exercise our legitimate rights as sexual beings and help our senior citizens to do the same.

### Attitudes, Misconceptions and Myths

Reuben Baetz, Executive Director, Canadian Council on Social Development, has characterized the stereotype of the elderly person:

The majority of the general public has only one model or picture of the aged, which would most likely be that of a person with wrinkled skin, absent teeth, silver grey hair, or no hair at all.

This person would have a poor memory, especially for recent events: Memories of childhood on the other hand are vivid. His health is generally poor; he is without vigor and is sexually dead. His ability to concentrate is poor, and when he talks he rambles. If he insists on driving a car, he is likely to be regarded as a hazard on the highway. On top of all this he has lost his competence, his independence, his job, and much of his income. In other words, it's downhill all the way. And if we happen to meet a retired person who doesn't quite fit into our model of the aged, we offer him the left-handed compliment of saying "my, but you don't look your age."<sup>3</sup>

These distortions of the aged have become so real among the younger generation that a new language is being spawned to explain the phenomenon: Psychiatrist Robert Butler calls it ageism, that is "just not wanting to have all these ugly old people around";<sup>4</sup> Sociologist J.H. Brunzel has coined gerontophobia, the "unreasonable fear and irrational hatred of the elderly." Even the elderly suffer from it, through a self-fear and self-hatred of their own advanced age.<sup>5</sup> The advertisers and makers of TV commercials simultaneously play on this fear and intensify it by pushing youth, beauty and sex at the buying

public. For example: Love Cosmetics distributes all of its products for women in phallus-shaped and phallus-sized containers; Loving-Care hair color claims "You're not getting older, you're getting better!"; Esoterica urges you to use its cream to fade out those horrid age spots, and so on. By contrast, older people in TV commercials need Absorbine Jr. to ease the aching joints of arthritis or Polident Green to bubble away unsightly denture stains. This is having its effect, for current research indicates that the middle years, which once began about 45 years of age, now with the youth explosion appear to have been pushed down to 40 or even 35 years.<sup>6</sup>

The misconceptions which follow are many. Society comes to regard the aged as all alike. They are not. Aged people are simply older individuals. For instances, one common misconception is that most aged people do or should live in institutions; in fact, only about 5 per cent of today's elderly are in institutions. Howard Irving has begun research<sup>7</sup> to examine the misconception that most old people have little or no contact with their family and relatives. The false notion that old people are not able to make decisions is most convincingly disarmed when one reads in *Playboy* magazine of panels and symposia held to discuss current moral issues such as drugs and homosexuality; the average age of the contributors is close to 50 years. There is also the misconception that old age is a second childhood during which people must be nursed and babied. Some

aged people become infirm and need special care but these are in the minority. Nor is it true that most aged people are in poor health.

We are concerned with one other misconception -- that aged persons have no sex life. This myth is slowly being exploded by researchers like Masters and Johnson and a host of authors who are finding a lucrative market in writing books directly and openly geared to questions of sex and old age. Two authors, Rubin and Newman,<sup>8</sup> have written a "how-to-do-it" book on sex for the aged, giving positions for intercourse geared to health and physical disabilities frequently encountered in later years. Masters and Johnson<sup>9</sup> consider their findings in this area to be their single most important piece of research. They have set out two fundamental constants for active enjoyable sex in the later years.

1. The individual must be in a reasonably good state of general health.
2. He or she must have an interested and interesting partner.

Sexually, the male and female can function effectively into their 80's, if they understand that certain physiological changes will occur and if they don't let these changes frighten them. Once they allow themselves to think they will lose their sexual effectiveness, then, for all practical purposes they will, indeed, lose it -- but only because they have become victims of the myth, not because their bodies will have lost the capacity to perform.<sup>10</sup>

Writing for Cosmopolitan magazine, Dr. David Reuben deals with the myth of sexless old age and sets out his three criteria for active, enjoyable sex in the later years.

The durability of the genitals is unsurpassed. Joints begin to show signs of wear after twenty-five years or so -- fifty years of hard use barely puts a wrinkle into the sexual apparatus. The average person can continue enjoyable sexual intercourse until the age of seventy, eighty or beyond provided he or she meets three requirements: adequate hormones, constant practice, and an interested and interesting sexual partner.<sup>11</sup>

The myth that old age equals the end of sex for men and women simply is not true. Through menopause and into their later years people can and do participate in and enjoy sex.

#### Research Findings

Arthur Henley<sup>12</sup> has noted that during the middle and later years of life the marriage partners' need for each other increases. This is the empty nest portion of the family life cycle when the children have matured and have gone to live on their own. Spouses are frequently unable to admit or otherwise communicate their needs to each other at this stage. In some cases the children may have served as buffers for the parents who are suddenly left with only each other and their friction and pain. For these and other reasons, one or both spouses may attempt to reach outside the marriage for love, attention, and affection. Here, too, it is not age that interferes with sexual relations but rather years of emotional stress that have no adaptive and

healthy outlet in the marriage. Disturbed sex relations may well be a symptom of deeper problem areas. Nevertheless, Henley has found that seven out of 10 healthy married couples over 60 years of age lead active sex lives. There is a healthy self-reinforcing spiral that can work here. Sexual energy regenerates itself. The more it is used, the more there is available to use next time. This is coupled with an increased desire to engage in sex. Add in a reduced fear of pregnancy and no children to interrupt love-making episodes and there is greater relaxation and enjoyment. And, as indicated earlier, there is more emphasis on the joy (quality) of sexual relations than on greater achievement (quantity).

All of this provides a receptive base for elderly couples who are faced with Dr. Reuben's frank admonition, "Use it or lose it." He states this from his findings that past age 60 a period of sexual abstinence of two months or longer effectively means the end of active sex for that individual. There seems to be an innate awareness of this need.

In old age masturbation again occupies the center of the sexual stage. Often intercourse is not readily available, though sexual urges may continue almost indefinitely. Masturbation is once again the solution. In old people masturbation may even be therapeutic in the sense that it keeps the sexual organs functioning and prolongs sexual activity.<sup>13</sup>

In this regard, Dr. Reuben is a strong advocate of active sex combined with sex hormone replacement therapy -- estrogen for

women (whose ovaries stop manufacturing at menopause), and testosterone for men (whole testicles stop manufacturing this compound at menopause). Reuben cites positive correlations between estrogen replacement and reduced heart attacks in women (men preferred the heart attacks to the feminizing side effects of estrogen) as well as between more active sex and reduced arthritis and improved heart health in both sexes.

Rubin and Newman<sup>14</sup> give the following rates of sexual activity for various age groups:

<u>Age Group</u>	<u>Sexual Relations (rounded figures)</u>
21 - 25 years	3 per week
31 - 35 "	2 per week
41 - 45 "	2 per week
55 - 60 "	1 per week
60 - 70 "	1 every two weeks
70 - 75 "	50% of this age group engage in coitus with some degree of regularity

The decrease in activity is not that substantial. The rate of activity in the later years is certainly much greater than the sexless myth allows. Even for a person of 90 years active sex occurs regularly enough to be tabulated.

Masters and Johnson<sup>15</sup> have found that in old age, as in all ages, ignorance of the facts surrounding sex is the greatest single deterrent to active enjoyment. They found that men and women "slow down" in terms of the physiological activity involved in sexual intercourse but that the four phases of the

sexual response cycle are valid at any age. These phases are:

1. Excitement (achieving erection for the male, and vaginal lubrication for the female);
2. Plateau (sustaining sexual excitement during insertion of the penis);
3. Orgasmic (ejaculation in the male and orgasmic vaginal contractions in the female); and
4. Resolution (reduction in sexual excitement and tension after completion of the sex act).

#### Sexual Aging in Men

The following chart compares the sexual response cycles of young and old men:

<u>Phase</u>	<u>Young Man</u>	<u>Old Man</u>
1. Excitement	Takes seconds to achieve full erection	Takes minutes to achieve erection
2. Plateau	Full erect and hard - full sexual tension	May become fully erect and hard only after insertion
3. Orgasmic	4-7 seconds for ejaculation completion (2 stages)	2-4 seconds for ejaculation (single stage)
4. Resolution	Gradual softening over minutes	Softening within seconds of ejaculation

While the sexual response cycle in the older male shortens or weakens (e.g. it takes longer to get an erection, it is not as hard and it softens quickly after ejaculation) other beneficial things happen. The older man does not experience the inevitability of ejaculating that the younger man feels. The older man's reduced drive and intensity to ejaculate enables him to achieve self-control and thus satisfy his sex partner to a



greater degree. Premature ejaculation problems decrease with age and ejaculation control.

Reuben<sup>16</sup> describes male menopause as beginning with the reduced capacity for erection which accompanies the reduced testosterone (male sex hormone) output as cells in the testicles begin to decay. Hormone replacement therapy can help to offset the resultant decline in maleness and thus restore sexual vigor and interest. Problems can become magnified out of all proportion during this period if the man does not understand the natural slowing down processes of his body. Fearing the loss of their manhood, some men will try to compensate for decreasing interest with futile attempts to increase their rate of sexual activity with a variety of women. Failure here becomes even more damaging. Others may turn to alcohol in excessive amounts. This sets up another vicious cycle for, according to Masters and Johnson, alcohol is the primary cause of secondary sexual impotence in men. Then too, the prostate gland which produces semen may enlarge with age to the point of becoming painful and interfering with urinary functioning. The prostate problem can be relieved easily with medical attention. Problems of reduced sexual functioning can be treated with a program of sexual rehabilitation combining hormone therapy and counselling of the man and his spouse or girl friend.

These hormones affect not only the energy level, but also the sleep patterns, weight, hair growth,

coloration and reproductive capacity of an individual.

A person in the throes of the climacteric (menopause), does not even know that something is happening inside his body, a physical change that is affecting his emotions. Yet he is plagued with indecision, restlessness, boredom, a "what's the use" outlook and a feeling of being fenced in.

While the blue-collar worker may be experiencing similar changes, medical experts agree that he is less likely to have the time or the opportunity to dwell on them than his more affluent, middle-class counterpart.<sup>17</sup>

Just as a man needs an understanding woman, a woman needs an understanding man to help her through her sexual difficulties at this stage of life.

### Sexual Aging in Women

As in the man, the sexual response cycles in the woman shorten and weaken with increased age:

Phase	Young Woman	Old Woman
1. Excitement	15-30 seconds to lubricate vagina	4-5 minutes to lubricate vagina
2. Plateau	Uterus elevates and vaginal canal increases in size	Reduced vaginal elevation and less increase in canal size
3. Orgasmic	8-12 vaginal contractions per orgasm	4-5 vaginal contractions per orgasm
4. Resolution	Gradual resolution. resume cycle quickly	Rapid resolution, not ready to resume cycle quickly

Masters and Johnson emphasize that menopause in a woman does not signify the end of her sexual life. For many

woman the hot flashes, depression, irritability and nervousness of menopause serve to make them sexually unattractive to their partners. At the same time, physiological changes in the vaginal walls make intercourse painful and unpleasant. The reciprocating effect can well mean the end of sex for the married couple unless they are made aware of the changes that are occurring in the woman in her later years - changes that mean an adaptation in sexual activity, not an end. Continued sexual activity is normal and beneficial for an aging woman just as it is for her partner. Because her ovaries stop producing the female sex hormone estrogen, her sexual processes slow down. As with men, continued sexual activity estrogen replacement therapy, and counselling to help women understand the life changes can all work to overcome the physical and psychological pain of menopause. Fortunately, a reduced fear of pregnancy frequently leads to an increase in sexual desire in elderly women, so a basic drive is working to spur her to search for help with her problems. The problems can be overcome and the process of decreased sexual activity can be reversed.

The sexual compatibility of aging man and women is striking and encouraging. The two charts above served to illustrate the reduced sexual response cycles of the aged male/female in contrast with young male/female cycles. Now we will combine the two to give some perspective to the issue of waning

sexuality.

Comparative Sexual Response Cycles in Later Years

<u>Phase</u>	<u>Old Man</u>	<u>Old Woman</u>
1. Excitement	Takes minutes to achieve erection	4-5 minutes to lubricate vagina
2. Plateau	May become fully erect and hard only after insertion	Reduced vaginal elevation and less increase in canal size
3. Orgasmic	2-4 seconds for ejaculation in single stage	4-5 vaginal contractions per orgasm
4. Resolution	Softening within seconds of ejaculation	Rapid resolution, not ready to resume cycle quickly

The compatability of the sexes becomes readily apparent. Each sex needs additional time in old age during the excitement phase to prepare for sexual union. In the plateau phase a less elevated, less extended vagina better accommodates a less-than-erect penis which after insertion becomes fully erect, causing less pain to a sensitive female organ. Single stage ejaculation permits more effective orgasm in the woman's own time. Her reduced vaginal contractions roughly match in time the man's 2-4 second ejaculatory stage, after which both sexes move quickly to the resolution phase together.

Physiologically, neither is able to resume sexual activity immediately. Both require a period of rest between coital acts and both necessarily take this rest because both organs move rapidly to a state of non-excitement.

### Implications for Professionals

The practitioner should be aware that sex continues to play an important role in the lives of the majority of middle-aged people, as it does in the lives of many old people. Research has shown that the greater a person's sexual activity in younger years, the greater his or her sexual activity in older years. In order for a helping person to counsel an individual or couples during and after menopause, he himself must feel that quite a few aging persons continue to desire an active sex life and he must be able to communicate his acceptance of this to such people. Many of those who deal with the rapidly growing number of older persons -- family and friends, doctors and social workers, staffs of old-age homes -- are either unaware of the data proving the sexual interest and capability of the aged if they cannot psychologically accept it. These helping persons need to be educated to the realities of sex in later years.

Counselling on sexuality and sexual adjustments should be available for old people. There is a need for booklets and pamphlets. For instance, if the man has difficulty maintaining an erection, the couple may need to use different coital positions which allow an erection to be held for a longer time. A wife may need to understand and know ways to stimulate her husband to achieve an erection.

Older people may have difficulty communicating with authoritative figures such as doctors. Many feel very guilty

about having sexual feelings or relations. Elderly people need authoritative figures to relieve their guilt about sex and about new techniques. A professional person with his own attitudes can directly influence their sexual lives. If he feels it is unimportant or feels they do not have sexual needs, then the older people will feel more guilty and this can become a "self-fulfilling prophecy." Professionals must realize that a negative attitude on their part can pronounce a death sentence on the sexual life of older people.

Oke and Zage<sup>18</sup> found that there are doctors working specifically with the aged. The medical director of a geriatric centre stated he was "not at all sure the majority of older people have sexual needs."

There have been no seminars or discussions on sexuality among the staff of another geriatric clinic. The clinic director does not know the attitudes the doctors at the clinic have about sexuality.

Sexuality has never been discussed at the annual meetings of Home Physicians for Homes for the Aged. The Chief Physician of Homes wrote to all the Home Physicians about problems of the aged. Sexuality was not mentioned by anyone. While this could mean that sexuality is not a problem, it probably means that it is an unrecognized problem.

Oke and Zage<sup>19</sup> also found that the age and cultural background of the staff makes a difference in how they regard

this topic. The doctors interviewed were well into middle age, one in his seventies. Their views were part of the era they were raised in. They viewed the aged as being more concerned with such basic physical needs as food, shelter, and bowel functioning rather than sex.

Men and women in nursing and old-age homes are probably the most sexually deprived of the elderly. Their environment is almost totally desexualized. Privacy is something they lose when they walk in the front door. Many homes for the aged are still sexually segregated. Even married couples may be separated. (This is changing, but it still goes on.) Such separation is mainly for medical reasons and is a family decision. Most homes have few single rooms or married couples' rooms. Usually there are bed checks at least once a night. For very ill people this may be necessary, but it seems to be quite an intrusion for people on standard care floors who can look after themselves.

We tend to treat old people in homes like adolescents. What are we protecting old people from? One director of a chronic hospital feels old people regress to infancy. They are only interested in such basic needs as food, getting an enema, a back rub and seeing a visitor. They become passive receptors of attention. Receiving an enema twice a week may be their only level of sexual activity. They go back to anal eroticism.

This seems pretty pitiful if it is the only way these

older people can get sexual pleasure or the only way we let them. We have structured most of the homes for the aged and nursing homes so that the aged do become dependent and are not allowed to have privacy. We are reinforcing the myths and misconceptions of sexuality in later years.

Masturbation should be accepted for those without partners as a normal way to reduce sexual tension. But one tends to receive very uncomfortable responses when asking doctors if they ever discuss masturbation with these people. It was felt that if people masturbated in younger years, they probably did it now. Judging from the doctor's discomfort in talking about this, one doubts if it is discussed with elderly people at all.

### Conclusions

We may be slowly acclimating ourselves to the idea that there is sexuality after age 65, but we are still a long way from actively helping older people to express it fully, or to deal with their feelings about it.

We need a campaign of sex education for the aged. For example, techniques of intercourse especially pertinent to the needs of older people should be clarified. Thus, sex in the morning may be preferable for those who tire easily at night. Certain coital positions may make intercourse more feasible for those who are crippled with arthritis.

Doctors have a responsibility to be more specific about



the sexual effects of medical problems. A man or woman with a heart condition, for instance, ought to know that a coronary attack during sex occurs much less often than the patient may fear is the case. If a person is taking nitroglycerine pills as medication there is no reason why he cannot take one before beginning intercourse, as a precautionary measure to ease his concern. A woman who experiences vaginal discomfort should be encouraged to have hormonal replacement therapy, even in her older years. A man facing a prostatectomy should be reassured that the likelihood of impotence resulting from it is comparatively small. And if a doctor has a choice among the varying techniques for that surgery, he should consider the sexual effects in making his decision.

Sexual activity can actually be therapeutic for an older person. Researchers focus on quantitative questions -- outlet, frequency, response. They seldom seek answers to qualitative questions involving needs, desires and hopes.

Clearly, there is more to sexuality after age 65 than just the act of sex. For a man, there is the satisfaction of still feeling masculine; for a woman, still feeling feminine; for both, still being wanted and needed. There is the comforting warmth of physical nearness and the pleasure of companionship. There is the rewarding emotional intimacy of shared joys.

Social workers can play their part in helping Canada's

senior citizens to include positive sexuality in their twilight years.

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## SEXUAL COUNSELLING

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Sexual Counselling involves helping the client with sexual feelings, attitudes and facts. This definition is distinct from that of sexual therapy which includes treatment of sexual dysfunction. Most sexuality occurs within a relationship and therefore most sexual counselling must involve two people. The individual may require assistance around past sexual traumas, present sexual confusion, orientation, fantasies and masturbation. Others may want to discuss physical handicaps and sort out realistic sexual options.

In order to consider more clearly what is involved in sexual counselling one must first look at the word "sexual." Too often the lay person and the professional equates sex with intercourse; as well, many people equate intercourse with the idea of reproduction. However, the vast majority of instances of intercourse are not for reproduction and a great deal of sex is possible without penetration. Even when pregnancy is hoped for, the sexual activity usually includes other goals such as pleasure and relating.

The many methods and problems of birth control must be taken into consideration when a counsellor deals with any heterosexual relationship. Both birth control and

sterilization become a couple decision in a relationship since the physical and psychological needs of both man and woman must be considered. When intercourse is for reproduction there may be many problems involving infertility of the man, woman or both; again, a sorting out of feelings and fact is required.

There is a further vast amount of sex that is not intercourse. For this reason the word "sexuality" is more appropriate than the word "sex." Sexuality includes a myriad of different ways to caress and stimulate both oneself and one's partner, whether one's partner is the same or opposite sex. Sexual fantasies are also a very important method of stimulation which can occur both unconsciously while one is asleep, or consciously, while one is alone or with a partner. It is helpful to think of sexuality as being similar to a large, varied smorgasbord of food. There is nothing on the smorgasbord that one must have and there is nothing on the smorgasbord that one must not touch in planning a menu. The individual's interest, attitudes, knowledge, comfort and personal tastes govern the choice. If another person is involved the menu may have to be altered according to that person's interests, attitudes, knowledge, comfort and personal tastes. Some people only choose to hold hands; others, or the same people at a different time, may kiss, caress, fondle, choose



various words or locations for their menu. Penetration of various orifices and from various positions may or may not take place. The range of feelings included may or may not include a climax of one or both partners, at the same time or at separate times. There is no standard of behaviour or feeling to measure up to, only the ones agreed upon by those involved. A sexual counsellor might have to help the individual or couple sort out their sexual preferences without allowing them to be unduly restricted by cultural ideas of what is normal, or by the counsellor's ideas of what is personally appropriate.

Society's decisions on normalcy unfortunately are based on intercourse for procreation so that the couple places undue emphasis on sexual performance rather than on mutual pleasure. The performance encouraged is always directed toward reproduction rather than simply sexual expression within the relationship. Is a couple making love or trying to make a baby? Are they trying to give pleasure and receive it or to reach some mythical idea of orgasmic intensity, the timing of which should occur at some proper point? Many couples sincerely believe that after an hour of beautiful love-making they have been total failures because they have not reached simultaneous orgasms on the level of epileptic seizures. There are many myths about the

normalcy of various caresses and stimulations, about ways, to become pregnant, about ways to prevent pregnancy and about fantasies -- when to use them and which ones are normal.

There are no easy answers to any of the sexual concerns. They are not automatically alleviated by stating factual information. Education is important but it must include an unbiased range of possible emotions and responses. Why a client asks a question can be more important than the question.

There is no right way to express feeling. In counselling, the individual feelings are the most important facts. The client is the expert on his or her feelings and responses. The counsellor's goal must be to help the client or clients find their own right way of sexual expression or even their agreed-upon manner of excluding sexual expression from their relationship, since avoidance is also part of the range of choice. The clients must bring their own motivations and goals to the sessions; the counsellor cannot and should not provide these. Of course if ethics are involved further soul-searching must be done, a point that will be enlarged upon later.

There will also be many clients who need help in sorting out their sexual identity and their feelings about past involvement in sexuality that has left them upset and

confused. Such incidents as incest, rape, homosexual fantasies, various types of sex play as a child, masturbation in the past and present are all areas where facts and feelings must be put into realistic perspective.

#### What is Beyond Counselling?

Traumatic events in the past may cause a person to have a phobic reaction towards sexuality in general or some aspects of it. It will not be enough for the professional to help such people sort out their feelings and look at the incidents more realistically. They will need actual therapy to help overcome their inhibitions. Other clients may have a specific sexual dysfunction such as inability to achieve physical manifestations of sexual feelings or control the timing of these physical expressions. The problem may involve painful intercourse, inability to achieve a satisfying height of emotional response and concern about lack of sexual interest. Sometimes these concerns can be alleviated through education and exploration of attitudes and feelings. However, when this is not sufficient it is important for the clients to be referred to a skilled sexual therapist in such a way that neither the counsellor nor clients feel that they are failures.

A counsellor must know his limitations and when and how to make an appropriate referral to a sexual therapist. Unfortunately, we have too few reputable and skilful sexual

therapists. It is to be hoped that counsellors will be willing to be trained to handle more difficult problems.

It is also extremely important for a sexual counsellor to realize that although the vast majority of problems do not have a physiological base there are various drugs, illnesses and physiological problems which can cause dysfunction. A physician must rule out these possibilities. Certainly any woman or man who is experiencing pain during penetration should be medically examined, probably by a specialist. It can be extremely helpful for a counsellor to know the doctors in his or her area since some are able to do a very sensitive examination so that the client understands clearly what has a physical base and what does not. If the problem does not have a physical base, the doctor can help the client realize that there is no shame in having anxiety, and that anxiety can cause a sexual dysfunction. Because the basis of the dysfunction is emotional rather than physical it is reversible.

The sexual counsellor should also be aware that over-counselling rather than referring can cause harm and intensify problems. The counsellor is using whatever skills he or she has with the client. If these skills are not sufficient the client feels hopeless because nothing is happening. If a client is not given the information about and

opportunity of seeking other types of therapy, that client's problem can intensify and result in feelings of depression and helplessness. Too many family and marital therapists work from the premise that a good relationship will automatically produce a good sexual relationship. This is not so. A couple can have an excellent pattern of interaction and communication in all areas but the sexual and for that they have no language for a negotiation around their restricted acceptance of sexual practices. Occasionally sex counselling can be done indirectly through marital counselling but by no means is this a universal answer anymore than is direct sexual counselling a universal answer for more serious sexual problems that need intensive therapy. For example a young couple married for two years were no longer able to achieve penetration in love-making. A marriage counsellor worked with them for three months emphasizing insight and communication. The sexual problem was still the same but by that time they were feeling more hopeless and more damaged. Direct sexual therapy solved the problem in three weeks.

#### Who Needs Sexual Counselling?

Since we have defined sexual counselling as a sorting out of facts and feelings around sexual expression, we must recognize that everyone needs it and is receiving it starting at an extremely early age. The baby first discovering its genitals

receives information about attitudes when mother smiles and allows it or quickly puts on a diaper and turns the baby's attention elsewhere. The natural explorations of the child into nudity and comparing genitals with playmates or wanting to look at adults' genitals are requests for information and attitudinal responses. The child usually receives definite attitudinal responses from adults if caught but the input of information may remain scanty. Certainly, an adolescent trying to sort out the sudden surge of confusing feelings and how to express them or not express them either alone or with someone else needs counselling on a formal or informal level.

All of us have to re-examine our sexual feelings and attitudes as we meet new life situations. We may change partners or physical responses during life role or stress situations. We live in a changing society with new philosophies that frighten or challenge us. The client may seek professional advice to help cope with this. Will the professional be ready or be caught in the uncertainties of change?

#### Who Can Do It?

In one way everyone is doing sexual counselling. Parents definitely are. Even though they may not say one word about sexuality they are role modelling the heterosexual relationship. Their avoidance of the topic indicates to children that

it is a subject to be avoided. Too often our literature does the same thing or else goes to the other extreme and suggests a bravado around words and emphasizes physical performance.

The person who is recognized as a professional and who gives sexual counselling is thus doing it with the authority of his profession behind him. That person should have the training and skills to live up to the professional authority he carries.

Unfortunately, because we are all sexual human beings and have sorted out some sexuality for ourselves, there is a tendency to feel that we are capable of giving sexual counselling. Too often however, we are only passing on our own sexual biases and preferences and this can be very harmful to the client who has a different set of needs and expectations. There are some very definite skills and specific training necessary for a sexual counsellor.

#### What Training and Skill is Required?

##### (A) Knowledge

Since sexual counselling includes a great deal of educating, the counsellor must have basic knowledge. Besides having a large body of factual information, the sexual counsellor should know what cultural pressures and myths the patient might have around information and practices in all of the

following areas:

1. Sexual development from infancy to old age including physical, mental and emotional changes; an understanding of the factors that retard development and the stresses that cause regressiveness;
2. Sexual functioning of the male and female physiologically and emotionally with the same sex partner or opposite sex partner or in masturbation;
3. Sexual behaviour, including cultural values related to the sex of the individual of the sub-culture as well as the larger society; the place of masturbation, nocturnal emissions, fantasies, chastity, fidelity, celibacy, guilt, premarital and extramarital sexuality, sexual variations, prostitution, and fallacies relating to all of the above;
4. Development of the gender identity of the male and female; biological influences on this development;
5. Reproduction, contraception, abortion, infertility, sterility, pregnancy and childbirth; (These



processes must be understood biologically as well as for the emotional impact they might have on the individual.)

6. Interpersonal relationships from infancy to death including incest, inhibitions, sexual education, sexual communication in the family, courtship, sexual adjustment in marriage, the courtship process, premarital and extramarital relations, the single parent, the homosexual marriage, and the sexual problems of the divorced and widowed;
7. Medical problems (real and imagined) involving anatomical malformations, hormone levels, venereal disease, and anxieties around sexual practices;
8. Sexuality in other countries, cultures, and species; (Sexuality in perspective requires some understanding of this.); the history of the sexual attitudes and beliefs of our society and the findings of scientific studies in the area of sexuality;
9. Attitudes. (Any person brought up in our society cannot help but have some conflicts and emotionally laden irrational attitudes about

sexuality. It is important for a sexual counsellor to have sufficient self-awareness and acceptability to have awareness and acceptance of the sexuality of others. This means all expressions of sexuality that are not specifically physically or emotionally harmful.)

The bibliography for this article gives the potential sexual counsellor the necessary range of information and cultural values. Again it must be emphasized that this knowledge is not solely an intellectual attainment to be gained through books; rather it includes an emotional process that necessitates interaction with others on a feeling level of understanding.

(B) Attitude

It is important that the counsellor have an open, accepting attitude towards all expressions of sexuality that are not specifically physically or emotionally harmful. This is an easier statement to make than to define. The definition has to come from the persons involved in the sexual behaviour, not from the counsellor. For example, it can be very harmful for a girl to allow open-mouth kissing from various boys. It is not that the open-mouth kissing is physically harmful, but a girl who feels that it is a sinful thing to do (although she does it to keep friends and have some popularity) is

going against her own value of herself and doing what is to her a harmful activity. Another girl might have full sexuality with various partners but might have negotiated this activity both with her own morals and ethics and with those of her partners in such a way that it is not harmful to any of them yet offends what the counsellor may think of as acceptable behaviour. The counsellor, too, owes consideration to himself and his personal ethics; if the counsellor feels that the latter situation is offensive, then in honesty to himself and his client it might be better to make a referral elsewhere.

(C) Language

The counsellor must have a language of sexuality to be able to counsel in this area and it is important that this language be varied. Because the counsellor is comfortable with formal language does not mean that the client will be. The client may only be able to articulate his concern in street language. The counsellor should be able to reach out to the client and converse in the client's language.

Unfortunately, it is very difficult for either counsellor or client to talk easily, about sexuality. For example, this article is restricted as to the expressions that can be used. Male physical response can be alluded to

but not the actual mechanics of what the response consists of. If a counsellor attempted to help a client using such euphemisms, the sexual education given by such an attitude would be that sex is dirty and unspeakable. Rather than being able to alleviate anxiety, the counsellor would be reinforcing it. How much of our teachings and counselling contain such meta-communication? Is this really what we wish to convey? The counsellor must be aware of the social pressures and messages the client has received while living in our culture. They are handicaps which must be dealt with in a clear, sensitive manner and this requires a clear, direct and comfortable language.

(D) Approaches

It is helpful for the counsellor to have many types of approaches in order to help the client be more comfortable and open. Humour can reduce some clients' anxiety; for others it would be offensive. It is also important for a counsellor to be able to gain information in a way that does not cause anxiety. For example, a teenage boy might be terrified if a counsellor asked if he were having homosexual fantasies. A better approach would be for the counsellor to tell a teenage boy that most boys his age have homosexual fantasies and some have homosexual activities, then ask him if he does and if so does it ever bother him? This

introduction gives anxiety-relieving information and allows the client to be able to open up without feeling threatened and labelled.

(E) Skills

Because most sexuality occurs within a relationship, a sexual counsellor must be able to do relationship counselling. It is very important for the sex counsellor to be able to recognize when there are basic communication problems other than just lack of sexual language. The counsellor should also be able to recognize when two people are involved in a war and are using the sexual area as part of their ammunition, hoping that they can draw the counsellor in on either side of the battle; the counsellor should be able to sort out whose problem is being presented. Sometimes the problem is one person's pattern of willingness to be the scapegoat in a relationship. Sometimes, it is a culturally-inflicted problem and doesn't really exist in the relationship. Sometimes the problem is the family doctor's; he has an idea of normalcy and cannot accept their difference.

In addition to the inter-relationship skills, it is important that the counsellor be able to be comfortable with a system's approach to the situation. He then understands the effect of outside pressures and dynamics so that the clients can be assisted in dealing with them.

### Ethics and Values:

There are many conflicting value systems concerning sexuality. The absolutistic position tends to emphasize the righteousness and sinfulness of particular acts with clear unchanging guidelines of behaviour. The relativistic position emphasizes judging the acts in relationship to their effects. The ethics then depend on the situation and the relationship of events to circumstances. The hedonistic position emphasizes personal pleasure first with the consequences to others as not being of appropriate concern.

While the individual can choose an absolutistic position or hedonistic position, the sexual counsellor can only adapt the relativistic position for counselling situations whatever else is chosen for personal situations. Otherwise counsellors could only work with clients who are fellow absolutes or hedonists.

The relativistic position is a morality of consequences. The consequences to the individual contemplating an action are important. If the act would undermine personal values there is a negative consequence. If it would undermine self-esteem or physically endanger that person, then it would be unethical for him or her. If the action might do any of these things to the other person involved, again it is unethical. Furthermore, individuals have an ethical responsibility to the society they live in.

Going against the written laws of that society has a negative effect of them. Going against the unwritten laws in a flagrant manner can also be unethical. For example, a couple may have decided on ethical sexuality between the two of them in the privacy of their home. However, if that same activity in that same home were repeated on a chilly winter evening with drapes open, a spotlight on the couple and neighbourhood children watching, it would no longer be ethical. A further social responsibility is the lack of ethics around creating another human being for which one cannot take responsibility. These are all areas that the responsible sexual counsellor must consider from the viewpoint of his or her own personal ethics in working with other human beings. There is no reason or excuse for a counsellor to be involved helping one individual be devalued or devalue another person. The only way of knowing whether or not this is taking place is for both concerned partners to discuss their value systems and feelings with the counsellor.

The sexual counsellor must be able to discuss feelings and values in such a way as to allow the clients to make their decisions about sexual activities with full informed knowledge of what is possible and what the consequences might be.

Sexuality is a method of communication either

with oneself or in a relationship with another person. It is unethical for a counsellor to use any method of physical stimulation with a client. The counsellor would be using his or her authority as a professional to negotiate intimacies, whether these were rationalized as therapeutic for the client or not. This is not an appropriate method of communication in a professional helping relationship. Although the professional may feel that the counselling is being kept on a purely physical, unemotional basis, the client may not be able to keep uninvolved emotionally. Besides, the emphasis on performance outside of emotions is not a viable method of treatment, since an emotional relationship is an important stimulating ingredient for many persons' sexual response. To attempt therapy in a situation which leaves out such an important erotic input is to handicap rather than help the client. If the client is emotionally involved, the counsellor has then added a problem rather than solving one.

#### Summary

A sexual counsellor must be a well-trained relationship counsellor with considerable added training and education in sexuality. The training must include a clear philosophy, code of ethics, broad factual knowledge and specialized counselling skills and language in sexuality.



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EDUCATION FOR AND TREATMENT OF SEXUAL FUNCTION  
AND DYSFUNCTION IN A FAMILY SERVICE AGENCY

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During the four-year period 1972-75 the Saskatoon Family Service Bureau, an accredited member of the Family Service Association of America, developed a program of education for and treatment of human sexual function and dysfunction.

For purposes of this program, sexuality was viewed as a natural, psychological and physiological function whose expression for procreation and recreational purposes constitutes the most intimate and vulnerable form of inter-human communication. Apart from a small percentage of organic causes, problems in human sexual function are learned. Hence, therapy for a committed couple consists basically of learning relationship and communication patterns that are supportive rather than destructive of normal human sexual function. Both the destructive communication-relationship patterns and successful therapy models have been identified and validated, primarily by the Reproductive Biology Research Foundation, St. Louis, Missouri.

Need Assessment

An agency's survival depends upon its ability to show that it responds to important community needs. It is difficult to determine precisely what needs exist or which ones to meet with

limited resources. Need assessment therefore requires the collection and interpretation of many facts, opinions and events. Caseloads, community events, pressure groups and national trends are some of the indicators to be read in forming an opinion about need for competence in the teaching and treatment of human sexual function and dysfunction. Requests for such competence from the Saskatoon community have come to this agency with varying degrees of clarity.

In 1974, as part of a regular program stream, the agency provided a group for adolescents in distress at home, school or with their peers. The adolescents approached the subject of human sexual function in a casual fashion, somewhat unsure that their otherwise trustworthy counsellor might panic either at the topic or at the breaking of the language barrier. The glossy sophistication of the teen-ager's language gave way quickly to a staggering naivete and basic discomfort with the topic of sexuality. A similar process was observed in 1975 with four different groups in the agency's marriage preparation program. Facts, a non-judgmental attitude and group discussion skills were the necessary and successful antidotes.

Problems in sexual dysfunction are described variously but cautiously by about 50 per cent of couples being seen in the marital and family counselling program. The agency has direct

interview contact with about 500 families per year. Need and demand for teaching and therapeutic programs in sexuality with couples were always recognized by family counsellors. However, competence was hard to define, much less acquire. In fact, treatment competence remains a particular problem because the agency subscribes to a dual sex-team approach as stressed by U.S. sex authorities William H. Masters and Virginia E. Johnson.

One way in which the agency monitors community need is by means of a weekly open-line television show with the local CTV affiliate, CFQC-TV. This program, now in its fifth year, begins with a seven-minute dialogue between the program host and the director of this agency. This dialogue introduces a social issue and sets the stage for telephone callers for the remaining portion of the half-hour program. Community interests, concerns and pressure spots begin to emerge and indeed are encouraged to emerge through the security of an anonymous telephone call to an empathic and informed guest. Human sexual function and dysfunction were alluded to in varying degrees on the program since about 1972. Consequently, in the spring of 1974, the television station took some risk for being in advance of community standards and agreed to a four-week series on sexuality. Human sexual function was discussed in terms of adolescence, aging, marriage, homosexuality and normal and abnormal sexual function. Initial apprehensions were demolished by massive and overwhelming tangible community

support for the series.

The response to the television programs by the community continued by way of formal requests from local service clubs for after-dinner speakers. The significance of these invitations, apart from the obvious, is that with some justification these clubs view themselves as being informed, up-to-date and in touch with the latest community needs and trends. Finally, major teaching assignments were requested of the agency from schools, churches, the University of Saskatchewan (Medicine and Social Work), and the civil service.

Outside the agency a number of studies and conferences have been completed since 1972 which describe a need for better programs in human sexual function. Position papers and formal public posturing have been expressed by pro-abortion and pro-life groups. Local family planning associations and school curriculum committees plus a group responsible for a province-wide assessment of family life education have all stressed the need for more teaching and therapeutic competence in the area of human sexual function. Finally, there is a ground swell of parents concerned about a non-censorship approach to the blue movies now in vogue at local movie houses. Many parents prefer adequate education about sexuality as the alternative to any censorship of the pornography at the movie houses.



### Resource Attraction

Funding or the ability to attract resources to a program often is seen as validation of need. Unfortunately, those who provide these resources often are a group apart from those who consume the resources. The alternatives are clear: find new resources, terminate the program or offer the program as part of a currently funded service. This latter option is in effect currently at this agency. Fees for marriage and family counseling are assessed on a sliding fee scale, with public and United Way dollars used to subsidize the difference between cost and fees paid. The treatment of human sexual dysfunction therefore is funded under the general marital and family counselling programs. Teaching assignments are always charged out at full cost. Inasmuch as demand in the areas of teaching and treatment currently exceeds agency resources, in effect it places the examination of other target groups in a position of low priority (e.g., schools, parent groups, teen groups in churches).

### Resource Allocation

The agency now finds itself recognized publicly as a resource in the area of sexuality while at the same time it is not sure of its own program skills or target groups. In the absence of priorities written into policy, the loudest cry for service often is the first one to be met. This is true provided the request is quite similar to, and not seen as a major departure from the

current program stream. That is, the agency already has a major investment in a teaching program at the college level, and a therapy program to the community at large. Clients in therapy with sexual problems, and the university will remain as the prime target groups for our therapeutic and teaching resources.

#### Competence

There are major problems in acquiring the capacity to respond in an educational or a therapeutic stream in the area of human sexual function. The agency's methodological bias and, indeed, training is taken from Masters and Johnson. The level of technology for treatment for human sexual dysfunction in Canada generally is regarded as being very low. Training is both expensive and remote. For example, this agency has invested more than \$2,000 in less than two years to provide a very basic training for its director at the Reproductive Biology Research Foundation, St. Louis, Missouri.

The standards of the Masters and Johnson diagnostic and treatment model are appropriately rigorous with reference to the need for a dual sex-team treatment model, the 24-hour on-call feature of the counsellors during therapy, a very intense and high frequency contact treatment model plus the access to a number of highly skilled consultants by virtue of the multi-disciplinary nature of human sexual function. Such resources are hard to find in the absolute sense, much less package into a workable

service.

The education for, and treatment of human sexual function is a field full of charlatans. They are allowed to exist for the usual reasons, not the least of which is the absence of any meaningful peer supervision or consultation. A vulnerable but needy public will insure the continuation of unlicensed and unrepentent sex clinics.

Public ignorance and fear of the topic of sexuality is expressed in many ways. Couples do not know where and how to present themselves and their problems for therapy. Requests for teaching are often inappropriate but highly specific. Teachers and others who invite the agency to present a program want to control the agenda without reference to objectives, presumably as a means of dealing with their anxiety about the topic. Also, requests to cover massive topics such as adolescent sexuality in a 50-minute lecture period is another example of an uninformed community at all academic levels. In Saskatchnewan there does not appear to be any academic stream which properly prepares professionals for the teaching and treatment of human sexual function.

#### Community Response.

Response to agency programming for sexuality may be described in three areas: popularity, efficacy and donor attraction.

The education-for-sexuality stream in the agency is

popular with, and respected by the community. Repeat and new requests for lectures and papers plus the onsite feedback indicate audiences who enjoy the material and the way it is presented (lecture, slides, tapes and group discussion).

Efficacy is a more difficult measure. Changed behaviour as a result of education or therapy is still an unknown quantity. The rationale for the agency to support continued practice in this area stems mostly from clinical judgment, unquantified client feedback and the hope that the practitioner can duplicate therapy methods which have hard research to validate their results.

The agency is assured of attracting enough financial resources to continue with the current practice and teaching load. However, any further programming will require the allocation of new resources yet to be secured.

#### Practice Essentials

There is massive relevance of the study, diagnosis and treatment of human sexual function to social work. A basic understanding of the problem, its dynamics, meaning to the client and client goals with respect to the problem are key social work principles which are likewise essential to the treatment of human sexual function. For example, a homosexual partner in a heterosexual relationship may present for therapy. A detailed case study can explain the developmental origin of this person's same sex preferences. The joint interview can focus on the current

interaction and dynamics of the problem as it affects the individuals in the relationship. Roles, communication models and the feeling-sensation spectrum shared by the couple can be identified by the therapy team. Through sharing clinical impressions with the client couple, a judgment is made about the meaning of the problem and the goals for therapy to be selected by the couple and therapy team. In this example, a number of options are possible.

The treatment of human sexual function requires an interdisciplinary team approach using a biologist and a behaviourist of the opposite sex. The necessity for two technical streams--biology and behaviourism -- is obvious. A physician and a clinical counsellor are examples of an ideal treatment team. It needs to be stressed that a dual sex therapy team is mandatory if the therapists are to remain objective with patients.

Sexuality is an emotional subject, causing an understandable need for the therapists to be in a team to manage each other's counter-transference. Patient seduction is a real threat in the treatment of human sexual dysfunction. Moreover, it is reassuring for a couple to be represented in therapy by the same sex therapist.

Co-therapist interaction is very important, with the lesser important therapist being the one who is talking, while the most important therapist observes the couple's response and

looks for what more is needed to help the couple understand. The co-therapy team, through their own interactions, also provides a communications model to the patient couple. The therapy team communicates to the client couple, as well as to each other, in a way that exemplifies such helping qualities as empathy, pace, self-determination, neutrality and self-representation. All feelings and sensations are accepted as valid and treated as facts in a non-judgmental manner. Use of consultants, confidentiality and sliding fee scales add to an almost endless list of social work principles and practices essential to the successful treatment of human sexual dysfunction.

The agency will pursue competence in the teaching and treatment of human sexual function and dysfunction. Better marketing of the services to more target populations will occur in response to the acquisition of more resources.

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MCMASTER UNIVERSITY MEDICAL CENTRE, HUMAN SEXUALITY CLINIC:

A DESCRIPTION OF THE FIRST YEAR

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The Human Sexuality Clinic at the McMaster University Medical Centre was developed as a part of a larger Human Sexuality Program that includes education, clinical services and evaluation.

Before the program was officially organized on April 1, 1973, there was an educational program in human sexuality for both graduates and undergraduates in the health science disciplines. In addition, professional individuals within the McMaster network of hospitals in the City of Hamilton were engaged in various forms of sexual counselling and therapy.

Four health-care professionals became concerned about the need for organization, coordination and development of a formalized program for education, clinical services, evaluation and eventually for research. These were Dr. John Lamont, an obstetrician gynaecologist; Dr. Wendell Watters, a psychiatrist; Dr. Stuart Smith, a psychiatrist; and the author, a social worker. Dr. Lamont is designated director and responsible physician; Drs. Smith and Watters are consultants and the author is the program coordinator.

The clinical branch of the program is designed to



give support to the other branches of education and research and vice-versa. A separate clinic for human sexuality is necessary because of an awareness of community need and the lack of health care professionals who are willing and able to deal with this need.

By building consultative and supervisory services into the clinical program we hope that more health care professionals will use it to improve their skills to the point where they can more comfortably help patients with sexual problems. Indeed, this is a main objective of the clinical service. However, as an aid to learning, the primary health care worker is encouraged to remain involved in cases that he or she has referred. A further opportunity for developing skills in counselling and therapy is provided through supervision seminar groups.

For the most part, referrals to the clinic have come either from health care workers in the hospital or from physicians in the community. Although each referring professional was offered the opportunity to participate in some or all of the therapy as an observer or co-therapist, only one community physician accepted the offer to remain involved and the therapy took place in her office. A much larger number of professionals in the hospital used joint sessions for professional education and the upgrading of skills. It became obvious that many referrals were made because the patient asked his or her family

physician for help with a sexual concern. The actual concern, however, was seldom clarified by the physician. Other referrals were made because the physician felt that the sexual activity was inadequate. A couple might not agree with his evaluation but they would dutifully come to the clinic as they were told. Some patients referred themselves directly. They either did not have a family physician or they felt their physician was unwilling to make the referral. Our emphasis on doctor referrals was mainly for the doctor's education, not because sexual problems are primarily medical.

Since many professionals found it difficult to clarify the patient's concern about sexuality, a number of the referrals turned out to be inappropriate. For example, one couple was referred because of the husband's concern that his wife was less responsive and therefore he had difficulty getting an erection. It took considerable assessment time to discover that the wife was having an affair and was not in the least interested in her husband sexually. The family doctor knew that the husband had had a vasectomy and that the wife had asked for birth control pills, but he appeared unaware of the significance of this contradiction and did not pass the information on when the referral was made. Extreme examples of inappropriate referrals were: 1. the psychotic wife who was on such heavy medication that she could barely articulate verbally, much less

respond sexually; and

2. the deeply depressed homesick woman from the Maritimes whose sexual interest had decreased as she struggled with her three preschool children and loneliness. Both cases were referred for psychiatric help at their own request.

Our statistics indicate that 45 (39 per cent) of the 119 people offered treatment either changed their minds or were assessed and not considered appropriate for treatment of a sex problem. Many factors accounted for such a high percentage. The couples and individuals had waited up to three months and some situations had changed. Also it took considerable assessment time -- occasionally up to four hours -- to sort out the real feelings and motivations of some of the more ambivalent cases. Little can be said about the 18 who refused a first appointment. There were 27 that did come in for assessment but for whom treatment was considered to be inappropriate. The reasons for this were quite clear. Three couples decided to separate and five men were not willing to continue and take even a first step towards closeness. Seven women were not willing to continue and take even a first step towards closeness. One couple was frightened of pregnancy but refused to use any method of birth control on religious grounds; nor were they able to consider other forms of sexuality. Four had no partners at that time and seven were referred for more intensive psychotherapy than the clinic

could offer. Two of these returned later for sex therapy.

The philosophy of the clinic is to accept all individuals or couples with sexual problems. This includes those with concerns about rape, incest, homosexual fantasies and practices as well as heterosexual couples living either separately, common law or in a marriage. The therapists find it very important to have training in conjoint and individual psychotherapy. The assessment phase requires the highest degree of skill: psychotherapeutic skills as well as skills and knowledge of treatment modalities around sexual dysfunction. During the assessment interview we take a detailed description of feelings and sexual practices as they are revealed in the present.

At the same time the extent of the patients' sexual knowledge is determined and expanded and includes a discussion of the range of possibilities for sexual pleasuring. This assessment focuses on the interactional level and emphasizes the importance of the needs of each partner and the degree to which these needs are communicated and met. The time-consuming lack of taking a detailed sexual history of the past is not necessary in a very great majority of cases.

Therapy is usually conducted by individual therapists. However, we have used therapists in pairs of either the same or opposite sex. There is no empirical evidence of difference in outcome. It is certainly easier and more interesting to work in pairs but it is not more productive and therefore a

waste of resources.

The appointments are often on a weekly basis but, if the couple has a limited amount of time together because of shift work or other commitments, the appointments may be spaced more widely. Nearer to the end of treatment the appointments may be as much as one month apart to allow time for the couple to feel confidence in the gains they have made. The assessment interview is an hour and a half long and the rest of the appointments from a half to one hour. During the first year the completed treatment involved from one to eleven appointments with the average number between four and five.

Treatment modalities for the 50 patient couples treated during the first year were as follows:

<u>No. of Cases</u>	<u>Education</u>	<u>Psychotherapy</u>	<u>Relaxation</u>	<u>Hierarchy</u>	<u>Medical Exam</u>
26.....	x.....	x.....	x.....	x	
7.....	x				
7.....	x.....	x			
3.....	x.....	x.....		x	
2.....	x.....	x.....	x.....	x.....	x
2.....	x.....	x.....	x		
1.....	x.....				x
1.....	x.....	x.....		x	
1.....	x.....		x.....	x	
TOTAL 50.....	50.....	41.....	31.....	33.....	3

Education is a major part of therapy. It is vital that the therapist help the couple articulate their feelings and ideas in order to help them gain a more realistic perspective. Many people have a narrow idea of normalcy. They feel guilty and anxious about actions or fantasies outside of their range. The wide degree of possibilities for sexual stimulation and lovemaking are discussed allowing the individuals to choose for themselves which activities appeal to them. Diagrams are used to make certain they know basic physiology. It is often necessary to explode sexual myths as sensitively as possible and to introduce factual substitutes.

Unfortunately, some couples were referred only because of the family doctor's perception of needs (for example, the doctor felt the couple should be having intercourse more often, or with simultaneous performance response). In other cases the doctor felt the response should be induced with one type of stimulation only and that anything else was unnatural, or that the man was not performing long enough to produce a female response. Some of these misconceptions were clarified with the medical practitioner in a tactfully worded letter reporting the patient's progress.

Every case has been unique. Even when the presenting problems were the same, the techniques required to help the different personalities varied widely. Furthermore, the

problem and the therapeutic techniques could be listed as the same, but the emphasis and the timing still varied considerably. In recognition of this fact, trainees in the therapy program are required to have basic skills in marital therapy. Although the focus with each couple begins with the sexual concern, it sometimes becomes clear that there is a need for a strong psychotherapeutic input. The couple's ability to communicate, to solve problems and to show empathy and insight quickly come to the surface during sexual therapy. It is necessary to expose the maladaptive pattern and to help the clients learn clear and direct ways of expressing their thoughts and feelings. This is especially important in the area of their sexual needs and feelings.

A method of deep muscle relaxation is taught to some of the patients for whom it seems appropriate. These are very anxious people who, in their anxiety, become so tense about performance they cannot feel sensations of pleasure and so do not have the physical responses to carry through their lovemaking to enjoyable intercourse. In developing the capacity to relax, the patient also becomes more aware of when his body is tensing up. This is an additional help, because the philosophy of therapy fosters avoidance of anxiety-provoking situations and encourages couples to achieve their goal through relaxed successful steps. Deep muscle relaxation has been

beneficial in aiding both the lowering of negative feeling and assisting in building up the positive sensuous feeling. Relaxation is used not only to desensitize but also to resensitize. Since the sexual response is a natural reflex, tension will interfere with the response.

Steps towards the couple's goal, which is usually pleasurable coitus, are in reality a hierarchy of scenes. The scenes emphasize lowering anxiety and increasing pleasure. For one couple the beginning scene may be holding hands on the sofa; for another, it be cuddling nude in bed. While practicing deep muscle relaxation the couple may imagine the next scene which has some anxiety for them and desensitize themselves in their imagination before they have to do it in actual practice. Any scene they do in actuality is done with communication about needs and pleasures of each of them so that they are learning to be more successful in each step. In effect, they are courting each other once again, but more successfully and with more assurance than they were able to do the first time. The pacing of the courtship is according to their needs, and the hierarchy of scenes is constructed according to the sexual interest of the couple. This is a significant departure from the standardized scenes that many therapists use for standardized problems.

One additional therapeutic method which has been used on specific occasions is the joint medical examination. It has



proven to be invaluable in cases where there is either painful intercourse or fear of penetration. The male gynaecologist, the female social worker and the male and female of a couple are all present. The female patient is in full control as to how much is accomplished in each session. She is prepared ahead of time by being taught deep muscle relaxation. The couple is given instructions on what might be done and why as well as some physiological education. Both the male and female patient are expected to duplicate any progress the doctor makes in touching or penetrating the female. A large mirror is used so that the female can see exactly what is happening and if a point comes where a speculum can be used she is able to see her own internal organs using the mirror. This is extremely helpful for women who feel they have some physical abnormality. It is also helpful for the male partner to learn that the female's fears and discomforts are very real and not merely a mechanism for sexual rejection. The male may also have a physical examination at the same time since he, too, can have fears of abnormality or have a physical problem causing concern.

Case Examples:

File No. 35

This was a very upset young couple who had been married for only three months. They defined their problem as being concerned

that the wife did not reach an orgasm. They were very embarrassed and shy and found it difficult to talk about sexuality both between themselves and with the therapist.

In actual fact, it was discovered that they were comfortable with, and enjoyed a wide range of caressing and that she responded both physiologically and psychologically. She had believed that her responses were at the wrong time and the only response that could count would occur at the same time as her husband's. The wife literally cried with happiness when she found she was a sexually responsive, normal female. Because of their narrow definition of performance he felt a failure as a man and she as a woman. They had reached the point where they were already avoiding attempts at lovemaking.

For this particular couple, education and some help around communication and the expression of feeling were all that seemed necessary at the time. A follow-up telephone call confirmed the fact that they no longer had further concerns.

File No. 61

This young couple was in their early twenties, married for two years and had a one-year-old daughter. The referral was from their family physician who reported that the wife was getting little satisfaction during intercourse and was concerned about a pain in her abdomen during penetration.

After the birth of the daughter their sexual pattern

had changed considerably. The spontaneity and fun seemed to have gone and at least for the wife it became a chore and a businesslike ritual. Since the pain commenced after the child's birth they were convinced that it was caused by something that had happened during the birth process. As a result, they were seeking a medical solution.

The two had a close, warm relationship but were not able to talk about sexual matters because of lack of language and inhibitions. The wife's rigidity was also evident in her need to be a perfect housekeeper and mother, allowing nothing to interfere with the elaborate role of rituals that she formed for herself. There was also evidence that both of them lacked confidence and showed their insecurity in different ways--he by being passive and not instigating communication and she by compulsive work and talk.

This couple was taught deep muscle relaxation and considerable time was spent helping them communicate about their feelings and needs both in their daily life and in their sexual relationship. A hierarchy of scenes was used and, in addition, they were encouraged to be more spontaneous with each other in planning activities and fun and less rigid in what they felt had to be accomplished in their daily life.

Because the wife was concerned that there was a physical defect as a result of the birth process, a physical examination was given to her with her husband present and the opportunity was

taken to give considerable education and develop further language for communication.

This couple was seen five times in all; by the end of the fifth week they had been having successful intercourse with no pain and with a more relaxed spontaneous enjoyment of the complete lovemaking process. For this couple it had seemed appropriate to use all of our therapeutic techniques.

File No. 38

This couple, who were in their late twenties, both appeared to have a low normal I.Q. They had been in therapy around the wife's severe depressions and suicide attempts over the past two years. Their ongoing worker felt that they were ready for sexual therapy around the wife's lack of sexual feeling.

During the initial assessment, it became clear that the wife was not interested in therapy or motivated to cooperate. She was withdrawn and depressed and admitted that she was thinking of separating from her husband. The ongoing worker for this couple was present at this interview and took them back into therapy with himself. After four months he returned with them again asking for sexual therapy. This time they were motivated and over a period of six sessions were able to resolve the sexual problem and, at the same time, considerably strengthen their marital relationship. Their ongoing therapist was a co-therapist during all these sessions, so that it was

possible for him to carry on with the psychotherapy at points when this was appropriate. At the same time, during sexual therapy there was considerable sexual education given, relaxation was taught and a hierarchy of scenes was employed with intercourse forbidden until they were ready for it. It seemed particularly helpful for this couple to focus on one problem and take it step-by-step so that they could learn to communicate and problem-solve. We found that these skills generalized into other areas of their relationship so that when a number of difficult problems hit them all in one week they were able to give each other support and withstand the upset. What is more important, they understood what it was they were doing differently and why it became easier for them to cope with life.

This case demonstrates that it is not only the middle-class, verbal couples who can profit from therapy. The focused, directive approach can easily be understood by those with lesser intellectual abilities.

File No. 77

This couple was in their mid-fifties. They had been married for four years. It was her third marriage and his second. Her first marriage began at age 13 when she became pregnant. It lasted for 10 years and she was divorced. The second marriage was ended by her husband's death. It had been a happy union. The present husband also had had a happy first marriage.

The presenting problem was the man's impotence. Originally, the couple had had intercourse a number of times a week, mainly at the wife's instigation. However, recently she had not approached him and he had tried to avoid her. Although the wife was very interested in sexual relationships, she had a rigid idea of how and in what way it should take place. Basically, it was very direct and rapid. Her husband, from this previous marriage was used to caressing and stimulating his partner for some time before penetration. The emphasis that this new method put on his penis as his only method of stimulating his wife naturally made him very anxious about his performance. This anxiety prevented that very performance.

This couple was only seen three times. The wife was very eager to learn more about sex. Through an authority figure telling her that it was all right she was freed to allow and enjoy a wider range of sexuality. The husband was then back in familiar territory and felt much more relaxed and comfortable. His sexual response returned and their love-making increased in quantity and quality.

With this couple, education and a week of giving each other exploratory caresses with no intercourse allowed was basically all that was needed to get them functioning comfortably together. They also learned a great deal about their

communication patterns, both verbal and non-verbal and sexual and non-sexual. They had a good relationship but their established patterns of lovemaking from the past did not fit together. They were both adaptable and motivated and so the therapy was short.

#### Summary:

There are considerable numbers of persons in the community feeling physical or emotional pain from sexual problems and concerns. Some of the problems and concerns stem from unrealistic expectations that they have gathered from myths depicted in movies, literature and peer discussion. A considerable amount of their concern can be alleviated by factual education and an opportunity for discussion.

Some professionals in the community are not able to deal with the sexual concerns of their patients and find it difficult to make referrals in a manner that is helpful to the patient or with information that is useful to the sex therapist. Some are unaware that they lack factual information in this field while others are not interested and prefer to make a referral.

It is important that a sexual therapist has flexibility in treatment modalities since some methods are more acceptable to certain couples than others, and the use of the couple's treatment-of-choice facilitates change towards their goals.

Psychotherapeutic skills are an important and necessary base for a sexual therapist since communication and relationships are heavily emphasized in sexual therapy.

The sexual therapist should also have had the opportunity to work out his or her sexual feelings and attitudes with other professionals in a small group setting. In our experience this is the best manner for expanding sexual concepts so that the therapist does not inflict his own sexual preferences on others, but rather helps them work out their own sexual expression according to their interests and values. In addition of course, there is a large basic body of factual knowledge to be learned.

The range of myths, feelings and ethics in our various sub-cultures are also important facts and the competent sexual therapist is as familiar and comfortable with them as he is with the physical facts and modalities of therapy.

A joint medical examination of husband and wife has proven helpful for dyspareunia, apareunia and in some cases for impotence. When the severity of a problem indicates therapy rather than counselling the therapeutic process can be greatly speeded up by the use of deep muscle relaxation, both for alleviating anxiety and increasing awareness and response to sexual feeling.

Complete treatment can be accomplished in most cases



in well under 10 sessions, with the arithmetic average during the first year being 4.5 sessions. These results are obtained by dealing directly with the present sexual problem, placing emphasis on the relationship and a minimal amount of time on the detailed sexual history. This focused, directive approach is useful even for those who are not part of the articulate middle class and does not require more than one competent professional in order to be effective.

## POPULATION ISSUES: IMPLICATIONS FOR SOCIAL WORK

Bert Marcuse, B.A., B.S.W., M.S.W.

The profession of social work has for decades operated within a rationale that "client self-determination" -- whether **the** client be an individual, a family or a community -- is a sine qua non of social work practice. We have argued that there are no absolutes, no definitive concepts that can be imposed on our client populations. We have claimed, not always in unison, and not always consistently, that the "dignity of man" is paramount. This is our categorical imperative.

In our Western society, schools of social work are graduating "specialists" who designate themselves as social planners, policy formulators, social advocates, change agents, community organizers, clinicians, researchers and administrators. Does there exist, within this proliferating body of experts a consensus on the values and goals that will make this "global village" viable 33 years from now when at our present rate of exponential growth world population will have doubled to 7 1/2 billion people? What will be the "quality of life" on this planet by the year 2008 when already our ecosystem cannot provide adequate nutrition to half our world population?

For many social workers these questions pose a painful dilemma. For some (in mainly affluent North America and some

countries of Western Europe) there is an escape, for a short time at least, into the protection of "agency policy," of conservative government designs for evolutionary social reform, or insular one-to-one therapeutic relationships. But these escapes are illusory. The fact of man's world-wide interdependence today is too obvious to deny. The death by starvation of a single child in India (or in Inuvik) must have meaning for every Canadian, every person on this planet. The complex interlocking of global population issues, of human ecology, of economics, of socio-cultural and political variables are both intimidating and frightening. But they cannot be ignored.

Florence Haselkorn, in discussing one aspect of the population issue, family planning, aptly summed up the implications of this matter, as well as the dilemma for social workers, when she wrote:

The thread of confused and conflicting values extends to other issues in social work's role in family planning. Concepts of target population and aggressive intervention hold potential risks of incursions into self determination and autonomy. Social work wants to be both an agent of change and allow people the freedom to resist change -- a social-philosophic tight rope not easily negotiated.<sup>1</sup>

Before considering some of the more specific implications of the population issue for social work it will be helpful to consider some of the overriding aspects of this

topic.

One of the most important considerations is that population growth is exponential - not linear. Many, or most people think of growth as linear (i.e. a child whose growth increases at the rate of say four inches a year, or as simple interest which is a fixed rate of interest on the original capital). This can be dangerously misleading because, in fact, population growth is exponential; this means that, like compound interest in which annual interest is based on the original capital plus accumulated interest, doubling of growth takes place in a much shorter period of time. Similarly, because use of our natural resources as well as the pollution of our environment goes on at an exponential rate, there must come a time when population growth and the depletion of finite resources reach a point of no return. As the report for the Club of Rome's project on the predicament of mankind by the Potomac Associates<sup>2</sup> shows, this may occur well before the end of the next century.

During the 20 minutes it takes to read this article 2,700 humans will be added to our world (birth rate minus death rate). In the year 1975 a population approximately four times the size of Canada will have been added to this earth. This rate of growth -- now at approximately 2.1 per cent a year -- means that world population is currently doubling every 33 years.

Put this figure into another perspective: At the time of Christ it is estimated that the world population was approximately 250 million. It took 1,650 more years for this figure to double to 500 million. By the year 1850 it had doubled again to 1 billion. By 1925, just 75 years later, it had doubled again to 2 billion persons. Today, just 50 years later, it has almost doubled again to 3.8 billion.

By the year 2000, if the current fertility rates in the underdeveloped countries are reduced by half (and this seems a highly optimistic hope in view of current data) and correspondingly reduced in the less-populated developed countries, demographers and other scientists are hopeful that the world population can be held to 6.5 billion people. This means that we are hoping for a world population by the end of this century no greater than  $6\frac{1}{2}$  times what it was about the time our grandparents were born.

Notwithstanding the other variables such as a more equitable distribution of wealth and property, rigid controls over our ecology, the effective control of pollutants and a rational advance in technology without abuse of our environment, it is glaringly obvious that planned population control on a global basis must be given immediate and urgent priority. Six years ago U Thant expressed this urgency for all of us when he said:

I do not wish to seem over dramatic, but I can only conclude from the information that is available to me as Secretary-General, that the members of the United Nations have perhaps ten years left in which to subordinate their ancient quarrels and launch a global partnership to curb the arms race, to improve the human environment, to defuse the population explosion... If such a global partnership is not forged within the next decade, then I very much fear that the problems I have mentioned will have reached such staggering proportions that they will be beyond our capacity to control.<sup>3</sup>

#### Population Issues: Relevancy of Family Planning Programs

Is the term "family planning" a euphemism for birth control or for population control? Or does it reflect an unwillingness on the part of Canadian and U.S. social work to offend or alienate certain vested political and/or religious groups? Certainly many North American social workers and social work agencies have taken an equivocal and timid stance with respect to birth control. With relatively few exceptions, their public position has indicated an unwillingness or inability to provide decisive leadership with respect to this vital problem.

Illustrative of this is the ambiguous position taken by the Canadian Association of Social Workers in their Policy Statement on Family Planning in March, 1974. The preamble to this statement concludes that: "The stance assumed by the Federal Government in the Family Planning field essentially promotes the right of the individual to control his/her own fertility and to exercise free choice in the practice of family planning".<sup>4</sup>

The statement goes on with a seccession of carefully phrased observations such as:-

The main objective of voluntary family planning is to assist all couples to plan the spacing and number of children so that they may (1) avoid unwanted births through prevention and treatment methods, and (2) plan for conception and treat infertility.

We must assist individuals to control their own fertility with responsibility and self-directiveness.

The Association should provide leadership in both the maximum utilization of government resources and in the establishment of a special program that will collect relevant data on population trends. The profession should disseminate information on infertility, fertility and changes of social and cultural attitudes of the population.

Clients should have access to social work, medical, psychological and religious assistance when they have problems with both infertility and fertility control.

Social workers must respect the client's rights to exercise self-determination in the use of family planning programs as well as in the selection of the method of spacing and limitation of child-bearing according to his/her personal beliefs and convictions.

Individual social workers should have the right to engage or disengage from family planning practice in accordance with his/her personal belief or convictions but should ensure that adequate professional referral is made.

Not once in this statement are the words "birth control" or "population control" mentioned. Instead, it expresses repeated concern for the "beliefs", "convictions" and "rights" of others for "free choice" and "self-directiveness" and appears unaware of the existence of the world outside Canada. Mankind, if it is to

survive, cannot have a privileged few exercise "free choice" or "self-directiveness" if by so doing the freedom of others is denied or limited.

In contrast to the CASW policy statement we have the unequivocal statement adopted by the National Association of Social Workers (U.S.A.), adopted by their Delegate Assembly some seven years earlier on April 13, 1967. It states:

Every child is born with the right to a family that has reasonable prospects for nurturing him successfully to adulthood. All individuals, regardless of income, should have access to knowledge of what constitutes good family life and the means to achieve it. The ability to obtain information and services for planning conception is an important prerequisite to good family life.

And in Canada, Recommendation One from the First National Conference on Family Planning (convened in Ottawa from February 28 to March 2, 1972 by the Department of National Health and Welfare) is equally forthright:

Family Planning policy, programs and services should encompass the full range of birth control methods, sterilization (vasectomy, and tubal ligation), abortion, fertility and genetics, as well as marriage and family (including adoption) counselling, and assessment, diagnostic, referral, and follow-up functions.<sup>5</sup>

Clearly, this is a mandate for appropriate social work involvement in the area of birth control in Canada.

Dr. Paul R. Ehrlich has commented on family planning in his text The Population Bomb as follows:

The failure of family planning in the field of population control has been brilliantly outlined by



Kingsley Davis in a recent article in the magazine Science. He points out that, "The things that make family planning acceptable are the very things that make it ineffective for population control. By stressing the right of parents to have the number of children they want, it evades the basic question of population policy, which is how to give societies the number of children they need. By offering only the means for couples to control fertility, it neglects the means for societies to do so." Or, as Justin Blackwelder once said, "'Family planning' means, among other things, that if we are going to multiply like rabbits, we should do it on purpose. One couple may plan to have three children; another couple may plan seven. In both cases they are a cause of the population problem--not a solution to it." Above all remember that planned, well-spaced children will starve, or vaporize in a thermonuclear war, or die of plague just as well as unplanned children. The story in the UDCs is depressingly the same everywhere--people want large families. They want families of a size that will keep the population growing. "Family planning" is all too often used to lock the barn door after the horse is stolen.<sup>6</sup>

It is not intended to suggest that social work does not have a legitimate and desirable role in the area of family planning. But the term family planning in a strict semantic sense means the spacing of children, determination of family size and, in a broader sense, therapeutic intervention in the case of infertility. This is an area that belongs within the purview of health and psycho-biology. What we do seek to establish is the need to distinguish between family planning as part of a relatively specialized health service and birth control as one form of social intervention that, in concert with world-wide planning in every aspect of the ecosystem, will

ensure not only mankind's survival but, it is to be hoped, the enhancement of the quality of life on this planet.

#### Green Paper on Immigration and Population

This much debated four-part study begins with a consideration of Canada's immigration policy. The first page offers the decisive observation that:

A consideration of Canada's population future cannot be divorced from world developments. On a global basis, the problems posed by population growth rates are prodigious. These rates mean that the world's population will inevitably double in approximately 35 years. No one can predict at what point this growth rate will slacken, as slacken it must sooner or later.<sup>7</sup>

This statement may be linked with another which states: "The plan of Action adopted by the World Population Conference held in Bucharest in August 1974 emphasizes that the problems in reducing birth rates and the problems of socio-economic development are inextricably linked."<sup>8</sup>

These two highly relevant statements appear to be somewhat divorced from the content of the rest of the Green Paper which is essentially a review of government immigration policy. Much of its content reflects long-standing official policy up-dated with statistical data drawn from the most recent reports on Canadian vital statistics and other relevant material from Statistics Canada as well as some immigrant attitude surveys predictably tending to reinforce the gov-

ernment's belief in the merits of its own position. Certain obscurant practices are still maintained, such as the designation of immigrants by such unscientific and irrelevant classifications as Negro and Jewish. Nor is it surprising that the Green Paper has been characterized by some critics as reflecting a certain ad hoc expediency or opportunism with respect to immigration policies.

Nevertheless the document cannot be faulted for its candid acknowledgement of the gravity and nature of world-wide population issues. Canada is one of the few countries in the world which can, by example and action, provide leadership and co-operation in the resolution of the multi-dimensional problems now confronting us. The implications for social work are clear and compelling. We must reinforce our government's global position. This will require much more than pious support of good intentions. It will require in-depth reappraisal of our roles as both social workers and world citizens, re-examination of our whole socio-cultural and economic structure and a reordering of priorities.

The Green Paper has other implications for social work of a more immediate nature. When read in conjunction with Statistics Canada's Vital Statistics Preliminary Annual Report 1973, it provides essential information on current Canadian socio-cultural and demographic factors which must be known if

research and social planning programs are to be maximally effective.

Some of the current trends in vital statistics are worth noting. The live birth rate in Canada was 15.5 per 1,000 of population, in 1973.<sup>9</sup> This rate is approximately one-third the birth rate in the "under-developed" countries of the world. Our fertility rate now stands at 1.9 children per married couple, a figure slightly below what demographers call the "replacement level," which is 2.1 for Canada. In other words Canada has reached Zero Population Growth. However, this is offset by immigration growth which, it is estimated, will mean that Canada's population may be in excess of 30 million by the year 2000. This is negligible in terms of population increases in Asia especially India, Africa and South America and by implication means that Canadian immigration policies will remain relatively restrictive. This becomes a moral issue which cannot be resolved short of world-wide concensus and planning.

It is interesting to note the trend in Canadian live births. In the period 1921 to 1925, the live birth rate for Canada was 27.4 per 1,000 of population with Quebec the highest at 35.5. In 1973, the most recent date for which figures are available, the Canadian rate was 15.5, with Quebec the lowest at 13.8.<sup>10</sup>

The trend in so-called illegitimate birth rates shows an increase from 2.2 per cent of all live births in 1921 to 9.0 per cent in 1973.<sup>11</sup> Numerous factors may account for this apparent four-fold increase. Among them are the greater permissiveness in contemporary society (reflected by a higher incidence of common-law marriages), greater frankness and perhaps better statistical data collection techniques.

Space does not permit discussion of other important family planning aspects of population issues. They include consideration of psychological and socio-economic factors in family planning (birth control) and the relationship between Gross National Product and family size. (Perhaps it would be more appropriate in view of the warnings of imminent world food shortages by the United Nations and other international food production agencies to substitute Calories or Protein Intake for the traditional and increasingly untenable concept of G.N.P.)

Abortion is another contentious issue that cannot be ignored because of its wide-spread use as a birth control measure. It is significant that at the annual meeting of the Canadian Medical Association at Calgary in June, 1975 a resolution was passed asking the government to repeal legislation requiring therapeutic abortions to be approved by an abortion committee at the hospital where the operation is to take place. In effect this means that abortion would become a matter of consent between

patient and doctor. This resolution should be considered in relation to a press statement issued in January 1975 by Dr. Bette Stephenson, president of the CMA when she stated that the close to 50,000 abortions in Canada in 1973 constitutes pathetic proof of the desperate need for a national birth-control program.

In our humanistically oriented society we profess, usually sincerely, to repudiate Malthusian or neo-Malthusian solutions to world population growth. War, famine and pestilence are not acceptable techniques of control. Yet a tragic reality is underscored by Jon Tinker, environment consultant of the London weekly, New Scientist when he states: "Then there is the armanents crisis: it is surely a peculiar obscenity that the rich powers can afford to spend some \$160 billion each year on weapons, while allocating only \$1.5 billion to agriculture in the Third World." 12

In conclusion we quote again from the final commentary in The Limits to Growth by the Executive Committee of the Club of Rome:

The last thought we wish to offer is that man must explore himself--his goals and values--as much as the world he seeks to change. The dedication to both tasks must be unending. The crux of the matter is not only whether the human species will survive, but even more whether it can survive without falling into a state of worthless existence.<sup>13</sup>

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## SOCIAL WORK EDUCATION AND FAMILY PLANNING

Benjamin Schlesinger, B.A., M.S.W., Ph.D.

Problems and issues stemming from rapid population growth are of urgent and universal concern. The United Nations and other international bodies, governmental and nongovernmental agencies in many other countries, place a high priority on efforts to support the quality of human life against the threat of an excessive rate of population growth. These efforts and the spread of knowledge about population dynamics have had a favorable impact on the social climate, particularly as it affects attitudes toward family planning.

The social work profession has long focused on institutional origins of social problems and on structural changes required to deal with them. Family planning activities thus offer a way of reaching basic goals of the profession, namely, the enhancement of freedom for the individual and the preservation of human dignity. Among the most important of the initial efforts was an institute on family planning held in 1967. It was sponsored by the Adelphi University School of Social Work in cooperation with the American Public Health Association, the Child Welfare League of America, and the Family Service Association of America.<sup>1</sup>

In a summation of the institute's findings, it

was "noted that the profession of social work has not been at the forefront of leadership in regard to furthering the cause of family planning, neither in terms of social policy development, nor in terms of programatic developments."<sup>2</sup>

The social work educators attending this institute came away highly motivated to study the responsibilities of schools of social work in relation to family planning as an area of social work concern and practice. Little evidence was presented at the institute to show that the professional schools had taken this subject area into account in curriculum planning in class or field instruction.

In 1968 the Graduate School of Social Work at Rutgers University sponsored an institute on family planning.<sup>3</sup> Delia Deschin summarized the institute:

Social Workers have a responsibility to consider their potential impact on family planning services and the conditions under which family planning services are made available, and should be prepared to take an advocate role for clients desirous of obtaining family planning information and supplies. Certainly social workers should be prepared at once to become involved, providing they have a clear understanding of their role in family planning.<sup>4</sup>

In examining how we can achieve this goal, she continued:

How a clear understanding of the social work role relevant to family planning is to be achieved is a difficult question. This will require discussions with practitioners and educators, and the development of field work placements for students on both the Master's and Doctoral levels. Some of the knowledge base belongs in the human growth and environment sequence, with added emphasis on health to complement the psychiatric emphasis. Some of the knowledge about family planning belongs in a number of other curriculum areas.

Many additional institutes and workshops must be organized to stimulate social workers to assume a responsible role and to equip them with the knowledge to ensure that family planning services are provided democratically as well as comprehensively. To achieve this goal, social workers will have to contribute more in the realm of social policy than has yet been done. Documented knowledge about the groups to whom family planning services have been denied makes it clear that there is a readiness to use the services once they are made available. This means that social workers have a responsibility to delineate the philosophy and practices that should underlie family planning programs.<sup>5</sup>

In 1969, the Annual Institute for Public Health Social Workers also had "The Social Worker and Family Planning"<sup>6</sup> as its main focus. At this conference Florence Haselkorn delivered a paper on family planning content in the social work curriculum. She stated:

When we turn to social work's interventive methods and its practice theory and principles (and why after all do we teach purpose, knowledge-values and sanction, if not to underpin informed practice and for competence in doing), again what is currently taught about working with all client systems and toward institutional and social policy change has direct application to social work's role in family planning. It may be true that we have not yet built up sufficient social work practice experience in family planning services, or begun to abstract knowledge from what social work experience we have, to know what modifications in methods or techniques may be required. But in any event, I would be wary of an emphasis in teaching specific techniques or programmatic discoveries that may meet with success but fall in the category of intuitive artistry or styles in strategy. For one thing we have hopefully moved away from "how to do it" methods courses. For another, although some fundamental principles

will prevail, methods as well as techniques are not eternally enduring and change in response to new knowledge and social change.<sup>7</sup>

In March, 1970 the Council on Social Work Education called an "International Conference on Social Work Education, Population, and Family Planning" which was held in Hawaii. The objectives were to:

1. Explore social work roles and functions in family planning and population dynamics, with particular emphasis on the social worker's contribution to attitudinal change.
2. Arrive at curriculum recommendations relevant to suggested social work roles and functions in family planning and population dynamics.
3. Relate the curriculum recommendations to different national systems of social work education and to various levels and types of education training, including basic professional programs, continuing education, pre-service and in-service training and training programs for auxiliary and allied personnel.
4. Initiate and encourage cross-national comparative teaching and research in schools of social work on family planning and population dynamics.

The working premises of the conference with respect to

the role of social work and social work education as they address family planning and population, appear to incorporate views that:

- optimize the preventive and development functions of social work
- recognize the necessity for working with and learning from other disciplines and professions without being too concerned with which is more important or central
- note the importance of advocacy
- recognize the unique value of paraprofessional case aides, volunteers, and all others not professionally educated who can be encompassed within the social welfare system
- encourage needed research in concert with other disciplines in order to acquire relevant knowledge and skill for social work's contribution.
- express some concern with over-control of family planning by the medical profession in some countries, which can restrict participation in and contribution of social work to the total effort
- recognize the limited curricular space within which social work education can address knowledge, skills, issues, and values related to family planning and population, and therefore the necessity of utilizing existing curricular structure wherever possible.<sup>8</sup>

In 1971, the Council on Social Work Education published a book, Family Planning: Readings and Case Materials.<sup>9</sup>

In 1972, the International Association of School of Social Work issued a reader's guide to population and family planning<sup>10</sup> and a "reference bookshelf" on this topic, to schools of social work in developing countries.<sup>11</sup>

The latest document is a report dealing with family planning education in schools of social work in developing countries.<sup>12</sup>

#### The Canadian Scene

The First National Conference on Family Planning, held in 1972,<sup>13</sup> included a recommendation relevant to our social work educational programs at all levels:

Federal and provincial encouragement and assistance, financial and otherwise, should be provided to ensure the planning and development of:

(a) Training programs for specialists in the planning of family life education programs, and in the related education of teachers, social workers, health and other professionals in this area.

(b) Curriculum materials and courses in family planning and family life education, social work, health and other university facilities or departments.<sup>14</sup>

#### Social Work Education and Family Planning

One of the submissions to the First National Conference on Family Planning dealt with the involvement of Canadian schools of social work in family planning. It was prepared by Marguerite Mathieu, Executive Director, Canadian Association of Schools of Social Work.

Replies to five questions were received from 12 schools, one of which reported no activity in the field of family planning.

The first question dealt with course content in the school's curriculum having a direct relation to family planning.

Seven schools answered that such content was taught as a component of a variety of courses such as social policy, medical information, human behaviour and social environment, sociology of the family, professional ethics and social work, health and well-being, family theory and intervention. One school was planning a seminar on human sexuality.

To the second question, on courses available to social work students in other units within the university, eight schools reported either borrowing from other disciplines or planning to do so. Such borrowings are available in demography, sociology, anthropology, geography and medicine. Some schools reported specific courses on population dynamics and human sexuality.

To the third question, on the availability of field placements, only two schools reported that they had no resources in the field of family planning to offer their students. Three schools mentioned having access to field placements in family planning clinics and six others referred to the availability of some experience in this field within the context of family agencies, children's agencies and hospitals. One school said it was exploring adequate placement to provide this experience.

The fourth question was on student involvement in research in family planning. Only two schools reported each



having one student engaged in research related to family planning.

To the fifth question, on faculty involvement, eight schools reported that faculty members were either doing research or had some form of community involvement either with a provincial family planning association or an agency. One reported a special issue of the school's journal devoted to family planning, and another mentioned a research proposal recently prepared by two faculty members.

A good follow-up to the National Conference was a three-day symposium in October, 1972 on "Human Sexuality and Fertility Services: Social Policy and Social Work Education" sponsored by the Canadian Association of Schools of Social Work, and supported by a grant from the Department of National Health and Welfare. Maureen Orton was project director.<sup>15</sup>

Most Canadian schools were represented, and were able to share concerns and ideas in the area of family planning and sexual counselling.

A grant from the Family Planning Division of the Department of National Health and Welfare enabled this author to compile a sourcebook on family planning in Canada, in 1974.<sup>16</sup>

It is of interest that the responsibilities of the Social Services Consultant of the Family Planning Division of the Department of National Health and Welfare include the

provision of professional consultation and technical assistance, on request, to public welfare departments, schools of social work and community colleges on questions related to policy formulation, staff training, curriculum development and the planning and organization of conferences in the area of family planning.

Through this consultation quite a few social work programs in educational settings have received guidance in content and help in obtaining suitable teaching materials. With the help of the Family Planning Division, a few schools of social work were able to build up a small library of basic books about family planning and human sexuality.

#### Teaching Family Planning

In 1974, Cenovia Addy, Social Services Consultant, Family Planning Division, Department of National Health and Welfare, reported that eleven schools of social work were offering courses in family planning and sexuality. She said:

At present courses are modified as the need becomes apparent. Most schools provide for student evaluation and presumably take their observations into account when planning the next course. Experience to date is probably not sufficient to enable an assessment of the possible impact of a course on the student's subsequent practice as a social worker. However, in the not too distant future it should be possible to obtain at least preliminary impressions regarding whether the social worker who has taken a course in family planning or human sexuality functions any differently than one who has not had such a course.

Meanwhile, there is need to examine, in much greater depth than is possible here, the differences and similarities in course objectives, course content, teaching methods, the rationale for the various approaches and the extent to which the course objectives are being achieved.<sup>17</sup>

The definition of family planning used by the Department of National Health and Welfare states that family planning is the knowledge and practices that enable couples to attain the following objectives:

- to avoid unwanted pregnancies;
- to bring about wanted births;
- to regulate the interval between pregnancies;
- to control the time at which births occur in relation to the ages of the parents;
- to decide the number of children they wish to have.<sup>18</sup>

Some guidelines for teaching family planning developed by the author include the following:

- (a) We have to be able to present both points of view on topics that are controversial in Canada.
- (b) We have to have in mind social, cultural, racial, sexual and religious differences in Canada related to the topic of family planning.
- (c) The course should have a Canadian focus since most of our students will work in this country

and time does not permit us to cover everything.

- (d) We have to introduce some demographic data about Canadian population and fertility trends to help our students get a Canadian perspective. A discussion of social policy, including political-economic situations in the federal, provincial and local areas, is needed.
- (e) The course should be practice focused so that students will be able to apply the knowledge once they graduate. Appropriate case material from the students' field experience may be usefully introduced into the seminar.
- (f) A seminar on family planning should include special lecturers, films, contraceptive information, and visits to a family planning clinic.
- (g) A full evaluation of the course by the students is necessary to enable us to consider their needs and continue to change our topics, content and methods of presentation in a meaningful way.

#### A Model of a Course on Family Planning

##### 1. Population and Demographic Factors in Canada

An overview of the demographic bases of

Canadian Society. Does Canada have a population policy?

2. Social Policy and Family Planning

A discussion of federal and provincial developments related to family planning since 1972.

3. Voluntary Organizations and Family Planning

An examination of the work of the Family Planning Federation of Canada.

4. Methods of Contraception

A full discussion of available methods of contraception and their effectiveness.

5. Sterilization

An overview of social, medical, cultural, and psychological aspects related to the sterilization of both men and women.

6. Abortion

An insight into the many-faceted aspects of abortion, including the views of pro- and anti-abortion groups.

7. Veneral Diseases

What is VD? The incidence, treatment, and

social implications.

8. The Delivery of Family Planning Services

The type of family planning clinics available in the local area. A visit to one of the clinics.

9. The Single Person and Family Planning

The problems facing teenagers and single persons who are sexually active and use or misuse family planning services.

10. Childlessness as a Way of Life

The new trend among many Canadian couples to remain childless.

11. Religion and Family Planning

How do major religious groups in Canada view family planning, sterilization, abortion?

12. Poverty and Family Planning

The issue of family planning and poverty, and the availability of family planning services to Canadian poor.

13. Films and Family Planning

An examination of Canadian films dealing with family planning.

14. Women's Rights and Family Planning

A discussion of how women's rights groups view the issue of family planning.

15. Ethnicity and Family Planning

The differences in attitudes towards family planning among Canada's ethnic groups.

16. Family Life and Sex Education

What is being done in our public and high schools to include family planning education?

17. The Social Worker and Family Planning

The role of social workers in Canada related to family planning.

18. Summary and Evaluation

Such a course would include guest lecturers, visits to family planning clinics, and visual aids.

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<sup>5</sup>Ibid., p. 76.

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## "SELF, MOTIVATION AND FERTILITY REGULATION"

Maureen Jessop Orton, B.S.W., M.A.

From February to June 1975, a group of 121 graduate teachers, social workers, nurses and physicians commuted to McMaster University from a 10-county area (Niagara Falls to Toronto) for some 70 hours of training in sexuality and fertility. The training program, offered under the auspices of the McMaster Schools of Social Work, Adult Education and Faculty of Health Sciences, was designed as a community learning project. Although the original initiative came from McMaster personnel, a basic project aim was to achieve a broad and balanced representation on the program's planning group, in the selection of group leaders and resource people from the community educational and service network, and in recruitment of student participants. A community seminar was held with agency and department heads for input on staff-training needs. This structure and content plus the use of a self-directed learning, problem-solving, small-group discussion format, all contributed to a stimulating experience where the planners, implementors and registered participants learned from each other. Project goals were three-fold: to develop the knowledge and skills of individual practitioners, who would in turn facilitate the development of community educational programs and services; and

to produce educational materials on the subject of sexuality and fertility.

Undergraduate courses in sexuality had been initiated at McMaster University in 1971 on an interdisciplinary basis for social work, medical and nursing students. The next obvious step was to meet the needs of graduate professionals in the community who find themselves under increasing pressure to educate and counsel people about sexual and reproductive concerns. There were four critical ingredients locally available to sustain such a project: someone to organize it, a nucleus of interested faculty to act as planners and key resource people, a nucleus of skilled group leaders knowledgeable about the subject, and the willingness of McMaster School of Adult Education to gamble and advance funds pending decisions on grant applications at the several stages of design and implementation.

A fifth critical ingredient was a family planning grant from the federal Department of National Health and Welfare. The total budget for the project was \$58,040. This consisted of a design grant for phase one, \$3,820; an implementation grant for phase two, \$39,700; plus tuition fees of \$14,520 (\$120 times 121 registrants). If we subtract the cost of development work (production of educational materials and one-half the time of the project director and secretarial assistant required for such a pilot project), the estimated cost per participant of the course was \$206. The budget does not take into account, of course,

the tremendous amount of time donated by members of the planning group over a two-year period.

Although government funding policy is focused on enabling Canadians to exercise their right to family planning, it is increasingly recognized that fertility concerns should be set within the generic context of human sexuality. It was, and is, our firm conviction that a brief workshop (at the public or professional level) in the techniques of fertility regulation cannot be expected to counterbalance the whole of human history -- a history of pro-natalist policies, the Christian concept of sexuality as sinful, the lower status of women, the double-standard of sexual behaviour, the conflicting double-standard of reproductive responsibility, and the inhibition to date of research and education in sexuality and fertility. Consequently, it seems essential that initial learning programs should be multidisciplinary, as comprehensive as possible, and focus on attitudes, values and policies, as well as theories and skills.

History has amply documented that sexuality and fertility are beyond the expertise of any one discipline, whether it be law, political philosophy, natural and social sciences, religious doctrine or (most recently) medicine. We can try to avoid the distortions that have plagued us, and the resultant suffering, if the professions share responsibility for developing programs. Resource people trained concurrently in the various professions can also provide back-up for each other in the community



and better ensure that public education toward problem prevention at least keeps pace with treatment services. Our planning group included representatives of the McMaster Schools of Social Work, Adult Education, Nursing, Medicine, Physical Education and Athletics; Mohawk Community College's Nursing Faculty; the Hamilton Board of Education; the Ontario Teacher Education College (Hamilton); and the Social Planning and Research Council of Hamilton and District.

### Program Objectives

In light of the above project goals and assumptions, we designed a program to assist participants of the four target professions toward the following general objectives.

#### A. Cognitive Objectives:

1. To acquire and be able to give others basic and relevant information on matters relating to human sexuality and fertility.
2. To understand and be able to discuss with others (individuals, couples and groups) the inter-relationship of their sexual behaviour and their reproductive behaviour with behaviour in other areas of their lives and their total life circumstances.
3. To understand and be able to discuss with others the inter-relationship of individual sexual-reproductive behaviour

and social mores and policies governing such behaviour.

4. To understand and be able to discuss sexual and reproductive behaviour, as well as laws and policies governing such behaviour (within the historical context of social and political change) in order to appraise concepts of individual adequacy, normality, health, or morality within the socio-political framework.
5. To be able to analyze one's institutional, agency and professional policies in the light of current views of professional responsibilities and individual rights (particularly with regard to access to knowledge and services concerning human sexuality and fertility) and, where necessary, to suggest alternative policies.
6. To know and be able to inform others of Canadian laws and of local services concerning sexuality and fertility and refer people when necessary (for example, to appropriate agencies for education and counselling on sexual function and therapy for sexual dysfunction; to fertility control services such as contraception, sterilization, abortion, and subfertility services; to unmarried parents and family support services; to genetic counselling).

7. To appraise professional roles (one's own and that of others) and community resources and services in order to be able to strengthen interdisciplinary and inter-agency cooperation and to point up potential areas for educational and service development.

B. Attitudinal Objectives:

1. To understand and be able to discuss with greater ease one's own attitudes and beliefs concerning sexuality and fertility.
2. To be able to initiate, with greater ease, discussions with others (individuals, couples and groups) concerning their attitudes and beliefs about sexuality and fertility so that they will participate more comfortably and fully.
3. To be aware both of the diversity of viewpoints and values (regarding sexuality and fertility) among people in this society and of their desire to make personal choices deemed appropriate to them.
4. To be able to apply this knowledge and sensitivity to one's professional role in such a way as to protect one's own rights and the rights of others.
5. To recognize and value potentiality for development in the roles of all those involved in programs and services, including consumer-participants.

### Program Design

Small group discussion rather than a lecture format was used to provide opportunities for exchange of attitudes as well as facts and opinions. This format also enables participants to act as resource people to each other, to develop a better understanding of different professional modes of operation and potential for development of each profession's role. The group process itself becomes a model of inter-disciplinary collaboration. Course participants were divided into 12 groups of 10 -- balanced as much as possible by profession, professional role (front-line worker, middle-management and upper-management), by sex, county (urban and rural) and agency of employment. In order to permit initial anonymity we separated people from the same agency or area network.

A self-directed learning, problem-solving format was also utilized. It is highly self-motivating. An initial definition of the problem also brings an immediate, pragmatic focus on factors to be avoided rather than on a general positive goal. The former is much more easily evaluated than the latter. This approach seems particularly suitable to the historically highly moralized yet relatively unstudied and unevaluated area of sexuality and fertility; in this area an awareness of the diversity of opinion in defining the problems is a major first step toward exploring alternative solutions.

The problem-solving format was applied to development

of resource materials, use of the small-group process and use of resource people. We developed a "book of problems," building in ideas received from the community seminar. These are typical problem situations encountered by each of the four professions, focusing less on the inadequacy of the individual student, client or patient and more on the appropriateness of professional response, agency policy, community resources and consequently on problem prevention. A matrix of issues can be applied to each of the problems. Groups were free to select problems and issues from the book or their own experience. Bibliographies were developed around the problem issues. Participants were given reprints of many journal articles, to assist commuters and to serve for future reference.

Groups discussed problems during the first hour and a half, using role-playing to clarify attitudes, etc. Then, prepared with questions and unresolved issues, three groups would combine to meet with a resource person for one hour. The last half hour of the evening's session was spent back in the small group, selecting problems for the following week, appraising readings and evaluating group process. Occasionally there was a panel presentation for all, followed by discussion in small groups.

The program included a historical overview and discussion of sexual behaviour, sexual development, socialization of sexuality, sexual function and dysfunction, health aspects of

sexuality, reproduction and fertility regulation, population and ecological issues, Canadian laws and social policy issues. This material, except for the last two topics, was approached within a session schedule paralleling the life cycle of human development. This proved essential in order to cover the wide range of problems coming to the attention of our professions. It also clarifies the interconnections between a problem at one stage emerging from incomplete development at a previous stage, and the dynamics of family relationships involving individuals at different life stages. Attempts to develop attitudinal self-awareness and sensitivity to the attitudes of others were made initially by introducing material and developing group cohesion and objectives over an opening week-end, and also by using films as a catalyst for group discussion on specific problem areas.

For the last six sessions participants partially regrouped to apply the previous content within three practice areas: education, counselling and therapy for sexual dysfunction. These skill sessions focused on participants' own teaching situations or cases, using games, role-playing, videotaping, simulated patients, case discussion and other techniques. To be eligible for skill sessions, participants could not have been absent for more than three of the previous 12 sessions. The option of sexual therapies was open only to those who had experience in marital counselling and were treating at least one case of sexual dysfunction. Of the 16 skill groups, one elected educative skills, three,

counselling skills; ten, a combination of educative and counselling skills; and two, sexual therapies.

The schedule of sessions was adjusted in response to participants' requests (e.g., there was an extra session on homosexuality; regular three-hour sessions were frequently extended to include films and several social get-togethers as groups disbanded). The original 60 hour schedule was extended to 70 hours: introductory week-end (three sessions), preschool development (one session), school-age development (one), adolescence (three sessions on normal development, the handicapped, and fertility services), adulthood (three sessions, on sexual function and behaviour, and fertility services), middle- and old-age (one), homosexuality (one), population/ecology (one), Canadian laws and social policies (one), skills (six).

In a project such as this, benefits accrue to the planners and implementors as well as to the participants. Consequently it is important, whenever possible, to use the selection of group leaders and resource people as another means to develop resources in different sectors of the community. In selecting group leaders we looked first for group leader skills, secondly for background in sexuality and/or fertility, and thirdly for a balanced mix by sex and profession and for as wide a distribution as possible among McMaster faculties, service network, and community agencies. Group leaders thus

presented a wide range of professional experience themselves and served as important models, both across sex roles and professional roles. Similarly, selection priorities for resource people with particular expertise and then a balanced mix. Group leaders had one introductory session prior to the program; resource people were briefed and counsulted individually. Many of the planning group members served as resource people at some point in the program and many of the group leaders did so in the skill sessions. In addition, another 23 resource people served for one or more sessions.

#### Enrolment

There were only two drop-outs from the course. Of the 119 participants completing the course, there were 48 nurses, 25 social workers, 20 teachers, 11 physicians and a group of 15 in allied professions. A break-down by professional role indicates: 60 front-line workers, 48 middle-management and 13 upper-management people (including educators of professionals). There were 15 from Children's Aid and other family agencies, 18 public health personnel, 37 hospital personnel, and 9 from Planned Parenthood and other fertility agencies. Of the teachers, 16 were at high schools, one was a consultant for a board of education, two were at community colleges and one was in university adult education. A total of 64 participants were from Hamilton and Wentworth County; the rest commuted for up to 100 miles a round trip. At least one-third had their tuition



paid by their employer.

This enrolment was the result both of a community seminar attended by 80 agency and department heads (which brought us many curriculum ideas as well as advance publicity) and of a vigorous public relations program. Initially planning group members had also secured endorsement of the program from their professional associations and community organizations. Since a balanced recruitment was important to project goals, as applications came in, planning group members followed up on lagging sectors.

#### Academic Credit

Participants completing the program received a certificate to that effect. A part-time McMaster diploma course in Clinical Behavioural Sciences granted credit for the course as an elective to their students. The Ontario College of Family Physicians approved the course toward their hourly requirements for continuing medical education. At least one teacher, on his own initiative, obtained  $1\frac{1}{2}$  credits from the Toronto College of Education toward his post-B.A. specialist certificate. Credit toward a bachelor's or master's degree would have been helpful for teachers, but it wasn't feasible for a course funded for only one year.

#### Evaluation

To date most seminars on sexuality have been evaluated by pre and

post tests of attitudes and knowledge. However, we found these either too simplistic for a professional course, not pertinent to the Canadian situation, and/or based on unclarified and debatable value assumptions. Lacking time and funds to develop an appropriate objective test, we developed two types of subjective questionnaires -- one to continuously evaluate group process and one to evaluate the overall program at its conclusion by participants, group leaders and resource people. Process evaluations monitored group process, resource people and materials, and provided a direct channel for participants to request adjustments in structure and content. Overall program evaluations sought an assessment of course benefits, appropriateness of structure to course objectives, resource materials, resource people and evaluation procedures, functioning of the group and group leader, suggestions for improvement, ways in which participants were applying their learning, changes in employers' and colleagues' expectations of them, and number of people they knew to be definitely interested in a repetition of the course (answer: minimum 250).

Evaluations were very positive: 30 per cent felt the course was "of greater benefit than anticipated" and 63 per cent said "as much as anticipated." A total of 70 per cent achieved all the attitudinal objectives, while 20 per cent achieved most of them; 28 per cent achieved all the cognitive objectives, while 50 per cent achieved most of them; 85% rated the skill sessions

as "useful" or more so. However, the choice compromises made by participants in their strong reluctance to regroup for skills was reflected in that only 34 per cent thought sufficient attention was paid to skills.

#### Comments on Design

The course should be lengthened, as one session on a topic is inadequate. It did not prove possible to completely regroup for the skill sessions by professional role or skill levels, as planned. It seems best to eliminate skills as a separate look and simply extend the content section of the course to allow time to make greater use of role playing. We would recommend 25 sessions over 22 weeks (75 hours). Although at participants' requests we showed more films than planned, participants did not rate them highly. We would recommend showing only a few films related to problem areas and scheduling one session for multiple previews of film resources.

Under the self-directed learning, problem-solving format, careful attention is needed to make good use of the resource period and prevent the agenda of one group from conflicting with that of another. We recommend a longer pre-program training session for group leaders to acquaint them with the materials and issues and enable them to achieve good group preparation for the resource period. As it is more difficult for outside resource people to fit into this format, we recommend using them less frequently and relying primarily on resource

people involved in the program planning. Resource people could alternate with presentations by participants and films.

Since an extension program lacks prolonged continuity to develop participants' skills, participants are bound to have varying abilities and willingness to learn by problem-solving and by discussing attitudes as well as facts. Program publicity should especially emphasize this focus and stress that students must be willing to participate fully in group discussions in order to obtain maximum benefits.

#### Production of Educational Materials

In addition to the "book of problems," overall recommended book list and nine bibliographies related to the book of problems, we have produced seven videotapes, two slide-tape programs and one paper:\*

#### "Our Sexual Legacy"

A one-hour videotape. Historical overview of changing truths to myths, from ancient Babylon to to-day -- Western laws, political philosophy, religious doctrines and scientific theories concerning male and female roles, sexuality and fertility. Dramatized readings with narration; summation poses questions for discussion. Useful

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\* A detailed report on this project is available through the university inter-library loan service to assist other centres to develop courses of their own. Written materials are appended to the report to enable wide reprinting. Audio-visual materials may be borrowed free from McMaster Health Sciences Audio-Visual Library by anyone at McMaster or in the McMaster health service network. Others may rent or purchase them from Audio-visual Sales and Rentals, McMaster University, Hamilton.

alone or as course-opener. Suitable for professional and all adult education, including senior high school, can be viewed in two segments.

#### "What Sexual Revolution?"

This half-hour slide-tape program documents the depth and extent of the political manipulation of the reproductive component of the human sexual drive. Over the centuries this social pressure has not only created the current crisis in population and ecology but also contributes substantially to many sexual problems. Analyzes such factors as sexual ignorance, fixation on sexual performance, as well as the guilt that still prevails around non-procreative sexual activities such as homosexuality, masturbation, oral genital sex and even appropriate use of contraception.\*

#### "Common Sexual Concerns"

A five-part videotape designed for professionals. Each 20-minute section may be viewed as stimulus for small group process. Tapes do not attempt to demonstrate counselling and therapy skills, but to encourage thought and discussion.

Part 1: Introduction -- philosophical and ethical framework, discussion of basic skills and goals for sexual counselling. Prerequisite viewing for other tapes.

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\* A slide-tape program still being planned at the time of writing is on self-image, motivation and fertility regulation.

- Part 2: Female Orgasmic Concerns -- interview with female simulated patient.
- Part 3: Female Concern Around Discomfort During Intercourse -- interview with simulated couple.
- Part 4: Male Concern Around Erection -- interview with simulated couple.
- Part 5: Male Concern Around Ejaculation Timing -- interview with male simulated patient.

"Jaye"

A 15-minute videotape. A roleplay confrontation between a physician and a male, paraplegic patient in a rehabilitation centre reveals the patient's sexual anxieties. Poses questions for discussion.

"Psychosocial Aspects of Fertility Regulation"

A paper linking certain theories, research data and issues from the literature of the bibliographies, with particular reference to young people. This paper was presented at Sherbrooke University, August, 1975, Session d'Information Professionnelle sur la Fertilité et la Planification des Naissances.

A FAMILY PLANNING TRAINING PROGRAM FOR  
SOCIAL SERVICE STAFF IN NOVA SCOTIA  
Sharon A. O'Connor, M.S.W., R.S.W.

Four main factors highlighted the need for a family planning training program for our social services staff.

First, the amendment to the Criminal Code of Canada in 1969 legalized the dissemination of birth control information. This change subsequently influenced the formation of our own departmental policy statement on family planning and in turn necessitated the development of a training program to keep staff informed about these and other new developments in the area of family planning.

Second, the previous lack of family planning educational programs, in both professional schools of social work and technical social service programs, made it incumbent upon our staff training unit to develop an educational program on family planning for our staff.

And, finally, the two factors which stimulated an urgent demand for a family planning training program were the realization of the primary preventive role of family planning and the acknowledgement that family planning is an integral part of supportive and rehabilitative services to clients.

For these reasons and with the conviction that social

service staff should be able to provide the same philosophy of alternatives to clients in the area of family planning as they would in any other area of intervention, the Nova Scotia Department of Social Services decided to sponsor a family planning training program for casework staff.

With the aid of a grant from the Family Planning Division of the Department of National Health and Welfare and with the assistance of Dr. Robert Ruotolo\*, from Associates for Human Relations and Counselling, a training project was designed and implemented. The aim of the project was to identify the training needs of social service staff in the area of family planning and to design and implement training sessions to meet the identified needs. The project consisted of three phases.

#### Introductory Research Phase

During the first phase of the project--an introductory research phase--two major activities were carried out: an exploration of existing resources and a questionnaire survey of social service staff throughout the province.

Our exploration of existing family planning resources resulted in the publication of a Family Planning Resource

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\*Dr. Robert Ruotolo served as project coordinator for the course and his assistance is gratefully acknowledged.



Index. This document was distributed to social agencies across the province and to all participants who attended the training workshops. The intent of the index was to familiarize social service staff throughout the province with information on federal, provincial and regional family planning programs and resources. The latter included not only such resource materials as agency policy statements and reading lists but also names of resource personnel available for consultation.

The questionnaire, which was distributed to staff in all provincial agencies, municipal agencies and to Children's Aid Societies, served as a major vehicle for identifying and documenting staff training needs in the area of family planning. It furnished us with a wealth of information of staff attitudes, knowledge and skills in relation to family planning. For example, an analysis of the questionnaire indicated:

- a) That staff required additional knowledge in order for them to feel adequate and comfortable in discussing family planning with clients; and
- b) That staff were not sure of their role in relation to the provision of family planning services.

Both of these concerns were incorporated into the training curriculum and a particular emphasis was placed on the issue of the role definition and clarification in relation to family planning.

### The Training Phase

The second phase of the project consisted of designing and implementing the training program. The objectives for the training program flowed from our questionnaire survey findings and were consistent with those presented by Miriam T. Manisoff in Family Planning Training For Social Services.<sup>1</sup> The objectives were broken down into the three educational domains of knowledge, attitudes and skills.<sup>2</sup>

#### 1. Knowledge

We wanted the participants at the family planning training workshops to become familiar with the following:

- a) What is meant by family planning and why family planning should be an integral part of social services;
- b) Accurate information and knowledge of contraceptive methods;
- c) The legal aspects involved in providing family planning information;
- d) The provisions under the Nova Scotia Health Insurance Plan regarding the coverage of family planning services;
- e) The anatomy and physiology involved in human reproduction;
- f) How to gather information from clients to assess their needs for family planning;
- g) The existing policy statement of the Provincial Department of Social Services and family planning policy statements in other social services agencies throughout the province;
- h) Existing family planning resources available at the federal, provincial and regional levels.

## 2. Attitudes

The following is the list of attitudes that we attempted to deal with at the family planning training workshops.

- a) The participants' appreciation of the importance of family planning policies which serve as guides for service delivery;
- b) The participants' sense of responsibility for initiating with clients an assessment of their needs for family planning services;
- c) The participants' attitudes and degree of comfort in discussing their own sexuality.

## 3. Skills

The following are several skills we hoped the participants would become proficient in during the workshops:

- a) The ability to identify and define the following indicators for family planning services:
  - economic factors;
  - personal and social adjustment factors;
  - physical and psychological factors.
- b) The ability to provide family planning services within the parameters of their job description.

The training workshops were divided into two one-day sessions. Day One was designed to allow for general information giving and discussion on family planning and human sexuality. It included such material as: birth control methods and their effectiveness; discussion on the participants' knowledge of and attitudes towards human sexuality and family planning; and the relationship of family planning to social

service work in general.

Day Two, on the other hand, was designed specifically to allow staff to relate family planning to their individual job functions. On Day Two of the workshop, staff were provided with information on agency policies in relation to family planning and were encouraged to participate in role-playing sessions on counselling persons with problems in the areas of family planning and human sexuality. During the role-plays the participants were divided into groups according to their role functions (such as child welfare, financial assistance, or probation). This enabled staff to clarify their roles in relation to family planning issues that they would meet on the job.

The actual training program lasted 16 months. During this time, eight two-day workshops were held throughout the five regions of the Provincial Department of Social Services. These workshops not only included field staff from all social service agencies in the province but also were extended to include child care and counselling staff from our three largest child-caring institutions.

The basic training curriculum was changed at the Nova Scotia School for Boys, the Nova Scotia School for Girls, and the Nova Scotia Youth Training Centre to meet the identified training needs of the staff at these institutions. The

curriculum changes allowed for greater discussion of particular problems which evolve from the very nature of institutional living.

#### Follow-up Consultation and Evaluation

In this phase, consultation services were made available to social agencies throughout the province to provide follow-up training for staff who attended the workshops. Unfortunately, we did not receive the enthusiastic response we had anticipated for follow-up training. Only a few agencies responded with requests for follow-up training to the family planning workshops. The training needs of these agencies for the most part centered around developing counselling skills with clients.

The evaluation component of the project an attempt to measure the impact of the workshops was not completed at the time of writing. The method being used to evaluate changes in the participants' attitudes, knowledge and service delivery practices is a comparison of questionnaire results. The results of the initial questionnaire survey are being contrasted with the results obtained from a similar questionnaire administered to workshop participants.

#### Foster Parent Training Course

The foster parent training course is not related to the family planning training program which has just been described. It

only appears in this paper because one session at the course dealt exclusively with the area of human sexuality.

To be a foster parent today is no easy task. Not only have we in the profession been increasing our expectations of foster parents, but we have been loathe to supply them with the necessary training needed to handle the new and ever-increasing demands we are placing upon them. It was for this reason that the Nova Scotia Department of Social Services conducted a series of six one-week residential training courses for foster parents.

The training courses consisted of 10 three-hour sessions covering such topics as: rights and responsibilities of foster parents; the impact of separation and loss on the foster child; the role of the natural parents; drugs and alcohol; learning disorders; the stages of child development; and sexuality and communication.

The three-hour session on "sexuality and communication" grew out of our concern for permanent wards (for whom we stand in loco parentis) being given an adequate sex education. It was our feeling that foster parents should be better equipped for their role in teaching their foster children about human sexuality. In addition, the foster parents expressed an interest in participating in a session on "sexuality and communication." Part of the reason for their interest in this

session seemed to stem from the fact that an increasing number of children in their care are fast approaching or are already in their teenage years.

The aim of the session was twofold:

- a) To provide the foster parents with an opportunity to examine their attitudes and values towards their own sexuality and that of their foster children; and
- b) To help the foster parents gain further knowledge of the whole area of human sexuality.

Each foster parent was given a packet of information which contained reading materials on human physiology and sexuality.\*

In each of the sessions held over the six weeks, the foster parents expressed concerns on a variety of issues. Here are a few examples:

- 1) Premarital sex and the moral issues involved;
- 2) "Proper" dating ages and hours;
- 3) Interest in the agencies' policies regarding birth control;
- 4) The effect that one child, who uses contraceptives, has on the other children in the home.

This last concern gave rise to much discussion and dissention, remaining unresolved throughout the sessions.

On their evaluation sheets the foster parents ranked the session on sexuality and communication highly. They stated that the information they received on how to broach such subjects

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\*We would like to thank the Family Planning Division of the Department of National Health and Welfare for the numerous publications and pamphlets they supplied for this course.

as the "facts of life" and "sexual responsibility" would be most helpful to them.

As a result of the tremendous response we received from the foster parents who attended last year's course, we are sponsoring similar courses this summer. We are also planning an advanced course for foster parents who have taken the basic one. During the advanced course, we hope to be able to follow up and expand on many of the discussions on human sexuality which were initiated last year.



<sup>1</sup>Miriam T. Manisoff, Family Planning Training for Social Services (New York: Planned Parenthood - World Population, 1972) pp. 6-7.

<sup>2</sup>Nova Scotia Department of Social Services, Proposal for Training Programs in Family Planning for Social Service Staff Throughout Nova Scotia (Halifax, 1973), pp. 5-7.

CANADIAN RESEARCH IN FAMILY PLANNING:

ITS IMPLICATIONS FOR SOCIAL WORK

Paul Sachdev, Ph.D.\*

Research activity concerning family planning made a belated and timid appearance in Canada. The limited professional investment in this area may be variously attributed to the lack of societal concern as to the need for regulating fertility among Canadians, and of the research auspices as well as the climate needed to stimulate research priorities in family planning.<sup>1</sup> The 1969 revision of the Criminal Code provisions concerning birth control and abortion and the creation in 1972 of the Family Planning Division of the Department of National Health and Welfare as a vehicle for federal programs of information, training and research in family planning, provide an impetus to research endeavours in this field.

However, quantitatively, the emergence of Canadian research in family planning is characterized in large measure by sketchy, noncumulative, unco-ordinated and amorphous efforts. The search for literature in this area can prove frustrating, especially when no previous review exists. The only pertinent work related to this is a comprehensive bibliography on abortion-related studies in Canada compiled by Claire Heggteit in 1974.<sup>2</sup> Also in

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\*The author acknowledges the critical and helpful comments of his colleague, Professor A. Comanor.

the same year Ben Schlesinger produced a source book on family planning in Canada in which he brought together a number of relevant papers.<sup>3</sup> Although this is a significant contribution to Canadian literature on the subject, it is by no means a comprehensive review of family planning research studies.

Qualitatively, most of the studies reviewed for this article leave much to be desired. First, barring a couple of studies the data mostly pertain to small, non-probability samples with dubious representativeness of the population from which they are drawn. Obviously, such samples limit the ability of the results for wider generalizations.

Second, although interesting formulations and theoretical bases for the research questions are offered in some studies, there was very little attempt made in the way of controlled tests to validate the findings.

Third, certain data are merely based on suggestive insight, self-selected samples (i.e., volunteers) and imaginative speculations with little attempt to ensure the tenability of the conclusions drawn from them.

Fourth, in many instances the study sample is heterogeneous in important demographic characteristics: to wit, respondents differ markedly in terms of age, ethnicity, marital status and geographical background. Research indicates that these variables have an important bearing on the type and level of contraceptive

usage, degree of psychological and emotional proclivities toward contraception, etc. The differential composition of samples in various studies renders the comparison of study results impractical and seriously restricts the possibility of their replication.

Fifth, characteristically social workers are phobic about research enterprise and despite the considerable experience to be gained from descriptive clinical reports, social workers have made few empirical studies. Of the 65 studies and monographs reviewed, only seven were done by social workers.

Sixth, paradoxically most of these studies are directed toward and based on female population. Since it is held that effective contraception is contingent on the active co-operation and partnership of a man and a woman, as well as communication between them, a contradiction appears in our approach when the man's behaviour is de-emphasized.

Seventh, in most cases the researchers have given attention to a single or an insufficient array of variables in attempting to explain patterns of contraceptive practice. They tend to disregard the fact that the initial acceptance of contraceptives and their continued use is largely influenced by a wide variety of variables that operate interactively at each stage of contraceptive activity.<sup>4</sup>

Nevertheless, to state the above characterization is hardly to discredit the efforts of these researchers, whose contribution to the knowledge in the field is by no means un-

important. Partial knowledge is far superior to no knowledge. Our critique is intended merely to suggest that practitioners use caution in interpreting the data and, more important to underscore the need for systematic scientific and controlled research inquiries.

This review deals with empirical data derived from a wide range of sources such as case studies, descriptive accounts, unpublished papers and monographs, opinion polls, newspaper reports, surveys and clinically based observations. These discrepant data are included not because the author has compromised his methodological biases but out of concern that stringent criteria will possibly eliminate many exploratory efforts which are nevertheless significant. "Modesty and weaknesses of many of these studies are less important than the fact that they are done"<sup>5</sup>

It must be stressed that to locate and obtain the widely scattered studies was itself a difficult and at times frustrating job, and it is highly probable that many otherwise sophisticated studies may have been overlooked. To be sure, any such omissions are inadvertent and without prejudice and are not a reflection on the merit of these studies. As well, perceptive and incisive French data could not be included in the review owing to lack of facility for English translation. Of course, for these omissions and commissions, the writer alone is responsible as he is for errors in interpreting the studies reviewed.

### Plan of the Review

Fertility regulation and control is influenced by a combined effect of contraception, sterilization and abortion services. In order for a client to exercise a free and well-informed decision as to the method of conception control best suited to his or her circumstances, education and counselling form an integral part of fertility-related services. Finally, the dissemination of family planning information and services to applicants requires a variety of auspices.

The review on family planning will therefore deal with studies pertaining to contraception, sterilization and patterns of service delivery involving different auspices such as family planning clinics, physicians, nurses, pharmacists, and indigenous workers. Abortion studies are excluded because the federal government does not recognize surgical termination of pregnancies as an acceptable method of family planning. Counselling will also not be included as part of the review since it is dealt with separately elsewhere in this monograph.

Finally, while the review will be limited to Canadian studies, outside references will be brought in by allusion only to confirm the Canadian findings.

I Contraception: Knowledge and Use

#### A. Socio-economic Status and Contraception

A few recent demographic analyses suggest a continuous decline in

fertility among Canadian women.<sup>6</sup> Yet, the families from lower economic strata persist in high reproductive behaviour. The inverse relationships between family size and socio-economic status (as measured by income, occupational and educational level) has been noted by some studies. Virginia Elahi, in her survey of 300 married women heads of households aged 15-44 years (mean age 32.9 years) in Halifax, Nova Scotia, found that the completed family size at survey for the low socio-economic status groups (determined by income data from 1961 census tracts) was 3.6 children as compared with 2.5 for the high ones.<sup>7</sup>

Consistent with this survey, the Family Planning Home Visiting Project conducted in Vancouver involving 2,450 women (average age 29 years) contacted through house calls, reported a higher incidence of fertility among women with lower educational and income status as contrasted with higher educational and income status groups.<sup>8</sup> Another Vancouver survey of 309 respondents who came to the Vancouver Family Planning Clinic in 1965-1966, noted that women in lower socio-economic groups compared with those in the upper occupational categories tended to have larger families.<sup>9</sup> These conclusions are further confirmed by the Metro Area Family Planning Association Survey of the distribution of births within various areas of the city in Halifax, which revealed that the 1966 birth rate was approximately 300 per cent greater in the low socio-economic area than the high socio-economic area. In 1971, this

discrepancy persisted among high and low socio-economic groups.<sup>10</sup> Finally, M.E. Palko et al., citing data from the city of Toronto Census tracts in 1969, demonstrates that as income decreases, more and more families descend into high fertility.<sup>11</sup>

At the same time, these surveys argue that the poor families generally have a preference for fewer children than they actually give birth to. However, their ability to achieve the desired goal of lower fertility is impeded by personal, social, professional, and institutional barriers. Contrary to the popular notion that lower-class families are fatalist, tend not to plan, and feel powerless in controlling subsequent pregnancies, the Halifax study found that 75.5 per cent of the low socio-economic group thought every family could control when and how many children it had, as opposed to 67.3 per cent of the high group.<sup>12</sup> One unpublished survey was done by the Planned Parenthood of Toronto during 1972 to determine the attitude of the Italian population (99 per cent "blue collar"). Of the 1,043 households contacted, three-fourths favoured the use of contraception.<sup>13</sup> The Family Planning Home Visiting Project in Vancouver, referred to earlier, noted that of the potential women contacted among low-income families, 58 per cent requested detailed information on family planning methods and their use.<sup>14</sup>

K.E. Belanger et al. conducted a comprehensive study in the city of Vancouver between 1968-1971, using four groups of



women -- those attending clinics, those not attending clinics, those attending community health centres, and those living in public housing and classified as "poor" women. The authors found that the "poor" women were just as interested in using birth control methods at the time of first sexual experience as the women in the other three groups.<sup>15</sup>

In short, all the above studies unanimously conclude that a great proportion of low-income people desire to control their unwanted fertility and seek modern methods to achieve their goals. However, their failure to regulate their fertility is considered to be the result of unequal opportunities to obtain contraceptive technology and related services. Guided by the rationale that alteration in the opportunity structure will in turn produce effective contraceptive practice, between 1971-1973 the United Community Services of the Greater Vancouver Area instituted a demonstration project of active outreach services to disseminate information, devices and support among low-income families. The contraceptive use among these families was either absent or ineffective. The significant aspect of the outreach approach was that the project workers made as many contacts as necessary with 2,450 women of childbearing age. Public health nurses were also used as a secondary contact with postnatal and prenatal mothers. At follow-up six months after the last visit, the study claimed that three-fourths of the inefficient or non-users became efficient users.<sup>16</sup>

A comparable and extensive effort utilizing educational and facilitative services (e.g., baby sitting, transportation, referrals, etc.) to influence the contraceptive behaviour of low-income families was undertaken in 1973 by the Planned Parenthood Society of Hamilton.<sup>17</sup> Local women (called case-aides) were recruited and trained. They personally contacted 14,711 households in low-income neighbourhoods, and disseminated information on birth control. Among the Hamilton findings pertinent to the practice interest are: 1) among those identified as potential changers, 9.6 per cent made a change in the direction of more effective methods which could be attributed to the initial contact by the case-aides; 2) never-users were more likely to be influenced than ever-users; and 3) younger people (under age 30) appeared more prone to change their contraceptive behaviour than those over age 30.

Paul Mackenzie cites the use of public health nurses in the Kingston area who visit postpartum women and discuss with them the methods of birth control. He claims that this approach has proved effective in promoting and sustaining these mothers' interest in contraception.<sup>18</sup>

#### B. Unplanned and Unwanted Pregnancies Among Married Women

Unplanned and/or unwanted pregnancies among Canadian married women have been of growing concern in recent years.<sup>19</sup> National figures on the incidence of these conceptions are not available but through

extrapolation from the U.S. National Fertility Study it is estimated that unwanted pregnancies accounted for nearly 22 per cent of all live births between 1960-65.<sup>20</sup> In Canada, Sociological Research of Laval University estimated that in certain regions of Quebec about two-thirds of the pregnancies were believed to have occurred when couples did not want them.<sup>21</sup>

A highly systematic fertility and family planning study was done in 1968 on a probability sample of 1632 married women of reproductive age currently living with their husbands in Metropolitan Toronto. Judging by the percentage of the women reporting that their last child was unwanted, the authors noted that a little less than 15 per cent of all couples experienced unwanted fertility and this level "rises to almost 50 per cent for those who have more than four children."<sup>22</sup>

Another Toronto study conducted in 1973-1974 reached similar conclusions. Based on the preliminary findings of the study on 601 married women selected by stratified random sample in Metropolitan Toronto, Dr. R.W. Osborn noted that 14.2 per cent of them stated that they did not want their last child.<sup>23</sup> Virginia Elahi noted in the Halifax survey that nearly 40 per cent of the women in the low and 25 per cent in the middle and high socioeconomic groups had more living children than their desired family size.<sup>24</sup> In their study of 506 vasectomised men Carl F. Grindstaff and G. Edward Ebanks found that about 39 per cent of the total living children born to 499 couples were accidental.<sup>25</sup> Finally,

K.E. Scott and S.H. Stone, after surveying the attitudes of 197 consecutively delivered mothers (85 per cent married) toward their pregnancy, report that 37 per cent of married women did not want their current pregnancy.<sup>26</sup>

The research reviewed consistently imputes married couples' failure to realize desired family size to belated, sporadic, inappropriate use or complete non-use of any form of birth control devices. Some studies report that as many as two-thirds of these couples attempt no contraception during the sex act even though they want to forestall further pregnancies.<sup>27</sup> A national study of randomly selected Canadian men and women aged 15-49 years found that, of the married women, nearly one-fourth in Quebec and just under one-tenth in the rest of the country were unaware of any sources of birth control information; men accounted for a higher proportion than women in this category.<sup>28</sup> In the Metropolitan Toronto Study, Osborn observed that 57 per cent of the sample analyzed were "irregular" in the use of contraception.<sup>29</sup>

Another attitude survey of 673 people in Newfoundland done by an Opportunities-for-Youth group, revealed that although 93 per cent of them were aware of the pill, only 38.5 per cent were currently using any method of birth control.<sup>30</sup> The most startling conclusion of the Toronto General Hospital Study involving 928 abortion women was cited by the authors in these words: "A more difficult statistic to explain is that 68 per cent of the married women engaged in unprotected intercourse."<sup>31</sup> Consistent

with these findings, Janet Pool, too, found in a study of 802 randomly selected French and English ever-married women living in low-density housing units in Ottawa that although 97.1 per cent of them knew about at least one method of birth control, the proportion of women ever using one was much less than that.<sup>32</sup>

Research findings are almost unanimous that non-Catholics are more likely to be contraceptors in both ever-use and current use but this difference is being attenuated.<sup>33</sup> The difference in the degree of contraceptive use almost vanishes among young wives of Roman Catholic and non-Catholic faith.<sup>34</sup> These results are commensurate with the findings from U.S. studies.<sup>35</sup>

Research evidence suggest that foreign-born women (mostly of non-European and South European birth) as compared with women born in North America use contraceptives less. Also, they rely on less effective methods (e.g., rhythm, withdrawal) to prevent undesired pregnancies.<sup>36</sup> A few studies observe that women whose husbands are "blue collar" workers are less likely to use contraceptives.<sup>37</sup> Evidence as to the relationship between age and level of contraceptive use is not conclusive. R.R. Balakrishnan et al., Janet Pool, and the Vancouver study observed a higher level of non-use among older women (over 40 years of age) than their younger counterparts.<sup>38</sup> On the other hand, the findings of the studies done in Halifax and Hamilton claim a positive relationship between age and contraceptive use status.<sup>39</sup>

However, these studies are unanimous in their findings that younger, recently married women as contrasted with their older counterparts rely to a greater extent on the most effective method -- the pill. To wit, with increasing age women depend less on oral contraceptives and more on methods that are less efficient -- foam, rhythm, withdrawal, condom.<sup>40</sup> This indicates a widespread interest on the part of younger wives in the limitation as well as spacing of births since more and more of them prefer to work outside the home and not to have children, at least during the early years of marriage. The relaxed attitude of older wives toward effective contraception may indicate a belief that they are unlikely to get pregnant.<sup>41</sup> However, the trend among older women to use IUD's or be surgically sterilized is becoming increasingly evident.<sup>42</sup>

Lately a number of observers have expressed concern that the pill is falling into disfavor and a growing number of women are discontinuing its use because of physical and psychological discomfort and fear that its extended use will affect their health.<sup>43</sup> This concern is further intensified when the only other equally effective method, the IUD, has not gained in popularity despite its obvious advantages over the pill.<sup>44</sup> The low acceptance of this method is attributed to limited publicity as well as to physicians' overwhelming preference for the pill.<sup>45</sup> A.H. Latif and E.D. Boldt conducted a study of 462 practising physicians in Manitoba to determine their role in the delivery of family

planning services. The authors found that the physicians surveyed prescribed oral contraceptives to 82 per cent of their women patients, while less than one-third received advice and service in IUD's.<sup>46</sup> Prescription of oral contraceptives was the most frequent service provided by 93 per cent of the physicians surveyed in the Regina Family Planning Clinic Study.<sup>47</sup>

C. Unplanned and Unwanted Pregnancies Among Unmarried Women

The steady rise in the number of out-of-wedlock conceptions among young women and the consequent increase in the demand for termination of their pregnancies via abortion has been a cause for great concern among Canadian citizens and the government alike. Nationally, the number of illegitimate births in Canada has climbed from 4.8 per cent of live births in 1962 to 9.0 per cent in 1973, with some areas registering illegitimate births as high as 24.8 (Yukon Territory) and 26.6 (N.W.T.) per 100 live births.<sup>48</sup> More than three-quarters of these births occurred to women between the ages of 15 and 24 years.<sup>49</sup> As well substantial number of out-of-wedlock pregnancies are being submitted to induced abortions. Statistics Canada reports that, of the total abortions performed on Canadian women in 1974, 58 per cent were done on single never-marrieds.<sup>50</sup> It is reasonable to assume that most of these abortions represent unwanted or unplanned pregnancies.

All indications point to a massive increase in reported premarital sex among young Canadians,<sup>51</sup> and research offers

persistent evidence that much of their sexual experience occurs either without or with only minimal use of contraception by either partner. The studies under review report disparate figures on the total absence of pregnancy control measures ranging from one-third to as much as two-thirds of sexually active women.<sup>52</sup>

Contrary to the commonly held assumption that the erratic and non-contraceptive behaviour among unmarried women stems from their lack of knowledge about modern methods of birth control, research studies note equivocally that a very large majority -- anywhere from 75 to 94 per cent of the samples studied -- claimed familiarity with many of the methods as well as their use.<sup>53</sup>

However, one survey by the Calgary Birth Control Association noted that among 250 applicants for therapeutic abortions "knowledge of birth control method was generally poor."<sup>54</sup> It was not clear, however, how the authors arrived at the conclusion.

The question commonly asked is why unmarried girls do not protect themselves adequately during sex acts if pregnancy is not desired? At the conscious level,<sup>55</sup> the studies suggest that by far the most recurring reason relates to their fantasy that pregnancy would not happen to them. Among other reasons suggested for unprotected or inadequately protected sex acts are that contraceptives interfere with spontaneity of sexual relations, induce emotional and moral ambivalence, imply admission of intent and consequently carry reputational and self-definitional implications.



A minority of girls avoid contraception in order to consciously choose impregnation and motherhood.<sup>56</sup> Another deterrent to regular use of contraception is the circumstances under which their sexual activity takes place. In most instances, sexual encounters among unmarried people are inconsistent and unpredictable, rendering the use of some methods impractical.<sup>57</sup> Some American studies have demonstrated a positive relationship between consistency of frequent intercourse and regularity of contraceptive use.<sup>58</sup>

While poor frequency in the use of preventive devices can admittedly expose a woman to the risk of impregnation, the kind of methods used further influence the degree of risk involved in sexual experience. The studies reveal that the most common methods employed by unmarried girls are condom and withdrawal, putting the onus on the man to keep them from getting pregnant.<sup>59</sup> A significant number of them rely on the least effective methods; rhythm, withdrawal, douche.<sup>60</sup> Although the pill is widely known among this group, its popularity is quite low.<sup>61</sup> However, its adoption rate is increasing among women who receive birth control information from voluntary family planning clinics.<sup>62</sup> The I.U.D. is least known to younger sexually active females.<sup>63</sup>

## II Sterilization\*

Lately, contraceptive sterilization in Canada is rapidly gaining in

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\*Since this subject is dealt with elsewhere in the monograph, its discussion here will be brief.

popularity with both sexes as a method of fertility control. For example, about 30,000 vasectomies were performed in Ontario between April, 1972 and March, 1973. In Quebec alone, 15,329 vasectomy operations were done in 1972.

Although male sterilization is gaining in popularity, the incidence of female sterilization is still higher. In Quebec for instance, vasectomies decreased from 15,329 in 1972 to 8,460 in 1973 while the number of tubal ligations rose from 5,109 in 1971 to 21,282 in 1973.<sup>64</sup> In the Halifax sample, tubal ligation was better known than male sterilization.<sup>65</sup> Hunter noted that in the sample he studied in Vancouver, 78 women had applied for sterilization as opposed to only five men.<sup>66</sup> Pool found that in two-thirds of the cases among Ottawa couples, it was the women who had been sterilized.<sup>67</sup>

Other investigators such as Paul Mackenzie, Arnold et al., Pool, and Balakrishnam et al., also report a higher level of tubal ligation than vasectomies in the samples they studied.<sup>68</sup> More recently, data from Nova Scotia further confirm this trend. During 1974, 4,466 tubal ligations were performed as opposed to 1,381 vasectomies.<sup>69</sup> Two studies, one by the Regina Family Planning Clinic and the other by Latif and Boldt, noted that physicians surveyed in their samples reflected a marked preference for tubal ligations over vasectomy by prescribing the former on a regular basis.<sup>70</sup>

The couples who resort to sterilization are somewhat young (average age 37 years), have achieved their desired family size, and are highly motivated to control additional fertility. Many seek a surgical method of contraception after they have unsuccessfully tried other contraceptive devices to prevent unwanted pregnancies.<sup>71</sup>

A follow-up study done in London, Ontario, between 1966-70 involving 506 vasectomised men reveals that an overwhelming majority -- 95 per cent -- reported satisfaction with the operation and were willing to recommend it to their friends. Nearly 70 per cent of both husbands and wives claimed increased enjoyment in sexual relations. Only less than 2 per cent indicated diminuation in sexual pleasure following the surgery.<sup>72</sup>

### III Delivery of Birth Control Services

Given the contraceptive technology, the provision of family planning advice and material has been recognized as fundamentally medical service. Consequently, private physicians have been in the key role in delivering birth control services. Nurses, because of their unique opportunities for more relaxed conversations and longer contact with patients, are being recently recognized as having a significant part in the delivery of birth control services. In the United States, nurses are specifically trained to render family planning services in clinics, including physical examination and counselling.<sup>73</sup> In some countries auxiliary midwives are

allowed to prescribe the pill and monitor the side effects.<sup>74</sup> Prior to government support for family planning in Canada, the bulk of fertility-related services were carried out by the voluntary sector, notably family planning association and related clinics. They served needy groups and spearheaded the movement, despite legal and financial restrictions.<sup>75</sup> Today they continue to fill the contraceptive needs of a variety of groups.

A few studies have attempted to evaluate the experience of these service auspices in providing family planning information and service. It is consistently reported that family planning clinics are least preferred as a source of contraceptive advice and information. Many, if not most of the people, receive these services from their physicians. Based on a national sample of randomly selected men and women aged 15-49, the Canadian Facts study revealed that the family doctor was mentioned as a source of birth control information by 61 per cent of the male and 77.9 per cent of the female respondents (excluding Quebec). Only less than one per cent of the total sample even consulted the Family Planning Federation or its related agencies about contraception.<sup>76</sup> The study done by the Family Planning Center in St. John's, Newfoundland, made similar observations. That is, although 70 per cent of the respondents interviewed (all females aged 30-39) were aware of the centre, only less than 2 per cent had ever contacted it. But more than three-fourths indicated preference for a private physician as a source of birth control advice.<sup>77</sup>

More than three-quarters of the women surveyed in the Regina Family Planning Study thought that they were satisfied with their private physicians as the most desirable and easily accessible source of family planning service and only one-eighth (17.3 per cent) would consider contacting a clinic for that purpose. In actual fact, only 2 per cent had ever visited the existing clinic, although a fairly large proportion of them had heard of it.<sup>78</sup>

The Halifax study, too, noted that "most (86.7 per cent) preferred to see a private physician for contraceptive advice."<sup>79</sup> Consistent with the findings of the above surveys, the studies done in Hamilton, Ottawa, and Vancouver also noted that the private physician is the key figure in the family planning delivery system and the clinics, especially those related to family planning associations are the least consulted.<sup>80</sup>

The limited popularity of the clinics is partly because of a lack of enthusiasm on the part of the physicians about the need for such a delivery system. In the Regina Family Planning Survey, only 13.6 per cent of the physicians interviewed saw the need for a clinic to provide contraceptive services.<sup>81</sup> C.J.G. Mackenzie et al. found that less than five per cent of the clinic users in Vancouver were referred by a physician.<sup>82</sup>

Two studies attempted to assess the responsiveness of private physicians to the family planning needs of their patients. Latif and Boldt, in their study of 464 practising physicians in Manitoba, cited earlier, found that a large majority of them (74

per cent) not only consider giving family planning service and advice as a significant medical responsibility; but also provide these services and comprehensive counselling to their patients on request or on their own initiative. Obstetricians, gynecologists and younger physicians were found more favorably predisposed.<sup>83</sup> Paul Mackenzie, however, discovered a widespread reluctance on the part of practising physicians to take initiative in offering family planning services. Of the 500 women surveyed at 3 months and at 12 months following their delivery at two hospitals in Eastern Ontario in 1972, the author noted that 68 per cent of these women obtained birth control methods from their physicians only after they asked for them.<sup>84</sup> Reluctance to initiate discussion on family planning was also noted among physicians in the Regina Family Planning Clinic Survey.<sup>85</sup>

There is some tendency that younger, married, better-educated persons in high-status professions are more likely to indicate preference and have utilized private physicians. In contrast, less-educated people more than 40 years of age and women whose husbands are in "blue collar" occupations, rely on "other means" for information on family planning.<sup>86</sup> Two studies, one by the Regina Family Planning Clinic and the other by K.E. Belanger and Eleanor Bradley, report that young unmarried women tend to feel reluctant about discussing their contraceptive needs with a private physician for fear of being refused and feeling uncomfortable. Teen-agers in particular are least likely to seek

out a physician for birth control information.<sup>87</sup> Doris Guyatt, too, noted in her sample of adolescent girls who attended the Family Planning Clinic in Scarborough, Ontario, that 70 per cent did not feel free to consult their doctor about family planning.<sup>88</sup>

However, in contrast to the findings of the St. John's and Halifax studies, C.J.G. Mackenzie observed that younger (mean age 26.2 years) married women from relatively low-income groups, were the most frequent users of the Vancouver Family Planning Clinic.<sup>89</sup>

Two studies surveyed the attitude of nurses toward their role in the delivery of family planning services. The Regina Family Planning Clinic study noted that all 20 public health nurses surveyed regarded the doctors as the key source of contraceptive service and advice.<sup>90</sup> In the same study, 437 mothers of newborn babies were interviewed following the visits by the nurses. It was noted that while nurses most commonly initiated the discussion of family planning, they seldom referred these women to the clinic; private physicians received the majority of referrals.<sup>91</sup> In contrast to the above study, the Vancouver survey found that "a great majority" of 29 public health nurses interviewed saw the provision of family planning service as an essential part of their work and only one-third considered the physician as the chief source of contraceptive advice.<sup>92</sup>

The pharmacist is another critical outlet for the distribution, sales, and display of birth control devices, particularly

of non-prescriptive methods. According to one estimate, approximately 50 per cent of regular users of contraceptives, use methods sold without prescription.<sup>93</sup> A great deal of interest is shown in the United States in the pharmacist's role as an important component in the family planning delivery system.<sup>94</sup> Little research done so far on this in Canada. In 1975 Carl Grindstaff was conducting the most detailed study involving 50 per cent of all the pharmacists in Canada contacted through mailed questionnaires. The study proposed to examine the display policy of these pharmacists, their distribution of information material, media advertising of contraceptives, and attitudes toward the dissemination of material to young unmarried people.<sup>95</sup>

Two studies have demonstrated the use of indigeneous workers in providing family planning information to persons unable to use regular family planning resources because of communication, psychological and physical barriers. Since local workers are familiar with the language and culture of their neighbourhoods, they are more likely to win their clients' confidence. The project of outreach services deploying local women in Vancouver and Hamilton, cited earlier, demonstrated that non-agency based agents were effective in providing birth control information to low-income families through personal contacts, thereby improving their contraceptive practices.<sup>96</sup> Similar services have been successful in the United States.<sup>97</sup>



## Practice Implications

1. Research suggests that low-income people known to social agencies show a high concentration of unwanted fertility and perpetual childbearing. Since it is commonly agreed that high fertility contributes to many problems facing poor clients, social workers should assess poor clients' need for family planning services and make appropriate referrals.<sup>98</sup> However, the clients must always make the decision as to how many children they want. Research offers further evidence that low-income clients show a readiness to discuss their sexual and family planning behaviour openly and candidly when the subject is raised.<sup>99</sup>
2. Available research tends to offer some support to the idea that the outreach approach based on personal and repeated contact is a mode of reaching inhibited and low-income families that should be pursued. Social workers can be involved selecting and training non-agency based, indigenous workers who stand a better chance to gain rapport and to communicate with local residents and win their cooperation.<sup>100</sup>
3. Lack of acceptance of family planning services must not be interpreted as the problem of contraceptive technology alone, but one that raises a wide range of questions that might be explored in counselling. These include questions about motivation, attitude, personality traits, amount of persistence and other human factors considered essential in successful contraceptive activity.<sup>101</sup> After

all, contraception merely provides the means for fertility control when motivation and discipline already exist. The outreach projects reviewed de-emphasized the role of non-technological factors and did not advance far enough to assess the sustained impact of these projects.

4. The fairly high incidence of unplanned and unwanted pregnancies among married women living with their husbands suggests, perhaps poignantly, that a considerable number fail to realize their ideal family size despite the relative ease of access to most effective devices and information. This fact alerts social workers to direct more concerted efforts toward this group, which may have been mistakenly thought to know how to limit their family size. The strategy in dealing with this group of clients does not involve so much the question of making information and devices available as it relates to the dynamics involved in successful contraceptive activity. Social workers should evaluate such factors as the stability and satisfaction in a marriage, patterns of communication between husband and wife, agreement on desired family size, participation of the husband, financial stability and satisfaction with the roles assumed -- all factors highly associated with successful contraceptive behaviour.<sup>102</sup>

5. The patients on postpartum wards are known fertile women who are generally highly receptive to birth planning. Medical social workers therefore have an excellent opportunity to discuss the contraceptive needs of these patients. Research findings indicate

that group approach can be very effective in disseminating contraceptive information.<sup>103</sup>

6. Aggressive efforts need to be employed to make family planning services available to certain minority groups, particularly non-European and Southern European immigrants (e.g., Spanish, Italian, Portuguese and Greek, immigrants) who, because of shyness, language barriers, and different value systems have difficulty using existing services.<sup>104</sup> Ideally, these services should be located in their neighbourhoods and manned by local persons.

7. Clearly, unless a substantial number of sexually active unmarried females are exposed to deliberate and regular contraception, an appreciable reduction in illegitimacy can hardly be achieved. Social and child welfare agencies, as well as schools, can provide social workers with easy access to potentially or currently sexually active girls with whom they can discuss the need for birth control. Research data indicate that insufficient attention is given to the male role in out-of-wedlock conceptions. The dependency of the female in many instances on her male partner for effective prevention of pregnancy further emphasizes the fact that any prevention program should attempt to involve male clients. Generally, men are found to be less aware of and assume lesser responsibility in contraception. Wherever the opportunity exists, social workers should direct greater educational efforts toward men.

8. Research indicates the low popularity of clinics yet in some

communities unmarried women and teen-agers prefer family planning clinics. A number of inhibitory factors (such as doctors' unpropitious attitudes, embarrassment, professional aura and the prospect of a long wait) prevent this population from effectively utilizing the private physician's services. Clinics can also attract older, less well educated, low-income people who visit physicians infrequently because of communication and psychological barriers. Since clinics are service-oriented, they give the appearance of benign medical facilities. Social workers can promote the support of family planning clinics and, where appropriate encourage their use by agency clients.

### Epilogue

A review of the literature and the process of winnowing and sifting the research findings generates a few impressions as to the gaps in, and future direction for research studies in this area. Truly, the volume of systematic research on family planning is small but considering the short period since the revision of Canadian law on birth control, the progress is nevertheless unmistakable. Positive gains from the uneven and haphazard growth of research reports has been the generation of interest in the field and of a rich pool of questions to be followed up by future studies. Some research needs become clearly identifiable:

1. National data on fertility behaviour, attitudes and knowledge of contraception.<sup>105</sup>
2. Examination of motivational, attitudinal, socio-cultural, and

psychological correlates of contraceptive behaviour. These studies can make a significant contribution toward the understanding of people who have access to contraceptive services but who do not wish to use them or use them ineffectively.<sup>106</sup>

3. Patterns of communication between husband and wife. These are believed to be crucial factors influencing the ability of the couples to plan and use contraception effectively.
4. Follow-up studies on male sterilization.
5. Studies on the ineffective use or non-use of contraceptives among young single women who become pregnant.
6. More replication (not duplication) of studies in order to validate the results.
7. More attention to research questions that have direct practice relevance for social workers. Social workers will view research findings as much more useful if the findings suggest in operational terms what they ought to do -- for instance, enhance practice skills, bring about change in the contraceptive behaviour of clients or attitudes that can alter their client's reproductive patterns.

This research ought not only to concern itself with practice alone but also with questions bearing on social policy. This has been emphasized for other areas of social research, and it is pertinent here also.<sup>107</sup>

## FOOTNOTES

<sup>1</sup>The author concedes the possibility of other inhibitory factors that might have existed prior to the repeal of restrictive federal laws on birth control in this country.

<sup>2</sup>Claire R. Heggteveit, "Selected References on Abortion," Community Health Section, National Health and Welfare, 1974.

<sup>3</sup>Ben Schlesinger, ed., Family Planning in Canada: A Source Book (Toronto: University of Toronto Press, 1974).

<sup>4</sup>A.H. Latif, Research into the Non-Medical Factors Affecting Contraceptive Practices of Women - At-Risk: A Conceptual Scheme working paper no. 1 (Winnipeg: Department of Sociology, Family Planning Research Project, University of Manitoba, 1975) pp. 8-10.

<sup>5</sup>Scott Briar, "Family Services and Casework," in Research in the Social Services: A Five Year Review, ed: Henry S. Maas (National Association of Social Workers, Inc., 1971), p. 118.

<sup>6</sup>Jacques Henripin, Trends and Factors of Fertility in Canada, (Ottawa: Statistics Canada, 1972), pp. 15-19; Cope W. Schwenger, "Why we need better family planning services in Canada," Canadian Welfare (May-June 1972): 18; Janet E. Pool, "Female Reproduction Behaviour, Part 1" (Department of Epidemiology and Community Medicine, University of Ottawa, February, 1975) pp. 48-50 (Mimeographed.); Monica Boyd, "Family Size Ideals of Canadians: A Methodological Note," Canadian Review of Sociology and Anthropology, (November 1974): 360-70; D. Ian Pool and M.D. Bracher, "Aspects of Family Formation in Canada," The Canadian Review of Sociology and Anthropology, 11 (November 1974): 308-323; People Pollution, Milton: Mr. Freeman, (Montreal: McGill-Queen's University Press, 1974), p. 116.

<sup>7</sup>Virginia K. Elahi, "A Family Planning Survey in Halifax, Nova Scotia," Canadian Journal of Public Health, 64 (November-December 1973): 516-517. These observations are confirmed by the U.S. data as well. See for instance, Sydney Furie, "Birth Control and the Lower Class Unmarried Mothers," Social Work, II (January 1966): 42-49.

<sup>8</sup>United Community Services of the Greater Vancouver Area, Babies by Choice, Not by Chance, a demonstration project, vol. 1 (1972), pp. 28-30.

<sup>9</sup>C.J.G. Mackenzie, G.P. Evans, and J.G. Peck, "The Vancouver Family Planning Clinic: A Case Study," Canadian Journal of Public Health 58 (February, 1967): 57.

<sup>10</sup>"Two Halifax Studies Report on Unwanted Pregnancies," Family Planning Population, 1 (Summer, 1973): 6.

<sup>11</sup>M.E. Palko, R.H. Lennox, and C.R. McQuarrie, "Current Status of Family Planning in Canada," Canadian Journal of Public Health, 62 (1971): 512.

<sup>12</sup>Elahi, Survey in Halifax, N.S. p. 517.

<sup>13</sup>Planned Parenthood of Toronto, "A Study of Attitudes on Birth Control and Family Size in the Italian Communities of Toronto," (mimeographed, 1972).

<sup>14</sup>United Community Services of the Greater Vancouver Area, vol. 1, pp. iii-iv.

<sup>15</sup>K.E. Belanger, Eleanor J. Bradley, and C.J.G. Mackenzie, "Social and Medical Factors of Women Attending City of Vancouver Family Clinics and of Women Not Attending a Family Planning Clinic" (Vancouver; Department of Health Care and Epidemiology, 1972), p. 27. (Mimeographed.)

<sup>16</sup>United Community Services of the Greater Vancouver Area, Babies by Choice Not by Chance, A Demonstration Project, vol. 11 (1973), p. i.

<sup>17</sup>Robert Arnold, Cyril Greenland, and Marylen Wharf, Family Planning in Hamilton (Hamilton: Planned Parenthood Society, 1974).

<sup>18</sup>Paul Mackenzie, "Postpartum Family Planning in Private Practice: a Baseline Study," Obstetrics and Gynecology, 44, (November 1974): 765.

<sup>19</sup>Gary D. Bouma, and Wilma J. Bouma, Fertility Control Canada's Lively Social Problem (Don Mills: Longman Canada Limited, 1975), pp. 19-22.

<sup>20</sup>Mary F. Bishop, "Voluntarism in Family Planning in Canada," in Family Planning in Canada: A Source Book, p. 88.

<sup>21</sup>Jules-H. Gourgues, "Sexualité et Planification des Naissances en Milieu Défavorisé Urbain Québécois" (1974).

<sup>22</sup>T.R. Balakrishnan, J.F. Kantner, and J.D. Allingham, Fertility and Family Planning in a Canadian Metropolis (Montreal: McGill-Queen's University Press, 1975), p. 135.

<sup>23</sup>Private Communication from Dr. R.W. Osborn, Department of Preventive Medicine, University of Toronto, dated August 13, 1975.

<sup>24</sup>Virginia K. Elahi, A Family Planning Survey of Halifax (Halifax: Dalhousie University, Department of Preventive Medicine 1973), p. 71.

<sup>25</sup>Carl F. Grindstaff and G. Edward Ebanks, "Vasectomy as a Birth Control Method" in Population Issues in Canada, ed. by C. Grindstaff et al. (Toronto: Holt, Rinehart & Winston of Canada Limited, 1971), p. 30.

<sup>26</sup>K.E. Scott and S.H. Stone, "The Unwanted Pregnancy: Inevitable, Burdensome, the Cause of Overpopulation," Annals of Royal College of Physician and Surgeon Canada, 6 (1973): 5.

<sup>27</sup>H. Grauer, "A Study of Contraception as related to unwanted pregnancy," C.M.A. Journal, 107 (October 25, 1975): 740; Arminee Kazanjian, "ACCRA: A Review of the First Two Years Research" (1973) p. 8 (Table 12); Arnold et al. p. 79; Esther Greenglass, "Attitudes Toward Abortion," in Family Planning in Canada: A Source Book, p. 212; Chatelaine Magazine, March, 1971, p. 62; H. Philip Hepworth, p. 33; Virginia Elahi, pp. 517-518.

<sup>28</sup>Canadian Facts, An Assessment of Mass Media Campaign for Family Planning vol. 1, (Toronto: Canadian Facts Co. Ltd., 1973), pp. 61, 89.

<sup>29</sup>Private Communication from Dr. R.W. Osborn.

<sup>30</sup>Opportunities for Youth, "Attitude Toward Family Planning in Newfoundland," (Report of the Provincial Family Planning and Sex Education Conference, St. John's, May 11-12, 1973) pp. 31. (Mimeographed.)

<sup>31</sup>Gail Sullivan and Susan Watt, "Legalized Abortion: Myth and Misconception," The Social Worker, 43, No. 2, p. 83.

<sup>32</sup>Pool, p. 53.

<sup>33</sup>Canada, Department of National Health and Welfare, Current Status of Family Planning in Canada (Ottawa, 1971) p. 19 (Table 17); Charles W. Hobart, "Attitude Toward Parenthood Among



Canadian Young People," Journal of Marriage and the Family (February 1973), p. 80; Balakrishnan, p. 79; Elahi, p. 517; Sullivan and Watt, p. 82; Pool, p. 55.

<sup>34</sup>Balakrishnan, p. 67.

<sup>35</sup>Leon F. Bouvier, "Catholics and Contraception," Journal of Marriage and the Family (August 1972,) 516; Lee Jay Cho, et al., Differential Current Fertility in the United States (Chicago: Community and Family Study Center, University of Chicago, 1970); N. Ryder and Charles Westoff, Reproduction in the United States (Princeton: Princeton University Press, 1971), p. 168; Arthur Campbell, et al., Fertility and Family Planning in the United States (Princeton, New Jersey: Princeton University Press, 1966).

<sup>36</sup>Balakrishnan, p. 61; Arnold, p. 89; Sullivan, p. 82; Pool, p. 55; Osborne; United Community Services of the Greater Vancouver Area, vol. I, p. 51.

<sup>37</sup>Balakrishnan, p. 77; Arnold, et al., pp. 82-83; Sullivan and Watt, p. 82; Elahi, p. 517; United Community Services of the Greater Vancouver Area, vol. 1, p. 49.

<sup>38</sup>Balakrishnan, p. 58; Pool, p. 55; United Community Services of the Greater Vancouver Area, vol. 1, p. 49.

<sup>39</sup>Elahi, A Family Planning Survey of Halifax, p. 76; Robert Arnold et al., p. 94.

<sup>40</sup>Balakrishnan, p. 67; Elahi, p. 518; Arnold, p. 95; Pool, pp. 66, 75-76.

<sup>41</sup>Elahi, Survey of Halifax, pp. 85-88.

<sup>42</sup>Elahi, Survey of Halifax, p. 88; Pool, pp. 75-76; United Services of the Greater Vancouver Area, p. 44; Arnold et al., p. 65.

<sup>43</sup>Janet E. Pool, Lorraine D. Mannell and John M. Last, "A Survey of Female Health and Reproductives Behaviour in Ottawa" (Paper presented at the annual meeting of the Canadian Association of Teachers of Social and Preventive Medicine, Calgary, June 1973) p. 8; Richard A. Bogg, "Therapeutic Abortion at the University of Alberta Hospital: A Sociological Analysis," May 10, 1973, p. 10; Marlene E. Hunter, "Application for Abortion at a Community Hospital," C.M.A. Journal, III, (November 1974): 1089; Balakrishnan, p. 137; United Community Services of the Greater Vancouver Area, pp. 7, 12.

<sup>44</sup>The extremely low level of interest in the I.U.D. has been unequivocally documented by the research reviewed. See for instance, United Community Services of the Greater Vancouver Area, pp. iii, 37-39; Arnold, p. 79; Paul Mackenzie, p. 764; Bogg, p. 11; Pool, p. 59.

<sup>45</sup>Unwanted Community Services of the Greater Vancouver Area, vol. 1, p. 37-39.

<sup>46</sup>A.H. Latif and E.D. Boldt, A Survey of the Physician's Role in Family Planning: The Manitoba Case (working paper no. 3., Family Planning Research Project, University of Manitoba, Winnipeg), pp. 13-16.

<sup>47</sup>"Regina Family Planning Clinic Study" (Final report, February 1975). (Mimeographed.)

<sup>48</sup>Statistics Canada, Vital Statistics, 1973, Vol. 1, Birth Catalogue #84-204, p. 67.

<sup>49</sup>Palko, et al., p. 511.

<sup>50</sup>Statistics Canada, Therapeutic Abortions, 1974, Advance Information, p. 2.

<sup>51</sup>See for instance Charles W. Hobart, "Sexual Permissiveness in Young English and French Canadians," Journal of Marriage and the Family (May 1972): 292-303; Eleanor B. Luckey and Gilbert D. Nass, "A Comparison of Sexual Attitudes and Behaviour in International Samples," Journal of Marriage and the Family (May 1969): 364-378; Joseph Phillip Hornick, "Premarital Sexual Attitudes and Behaviour: A Reference Group Contingent -- Factor Theory" (Ph. D. Dissertation, University of Waterloo, 1975), pp. 208-209.

<sup>52</sup>Paul Sachdev, "Factors Relating to the Abortion Decision Among Premaritally Pregnant Females" (Ph. D. Dissertation University of Wisconsin, 1975), p. 159; Irene Lipper, Helen Cvejic, Benjamin Peter, and Robert A. Kinch, "Abortion and the Pregnant Teenagers" Canadian Medical Journal 109 (November 1973): 852-56; Cenovia Addy, "Trends in Family Planning" (an address to the University of Saskatchewan, School of Social Work, November 21, 1973); Chatelaine Magazine, March 1971, p. 62; Martin Wolfish, "Birth Control counselling in an Adolescent Clinic," Can. Med. Ass. Journal (October 9, 1971); Doris Guyatt, "Family Planning and the Adolescent Girl," in Family Planning in Canada: A Source Book, p. 178; Stewart Meikle, "A Preliminary Analysis of Data Derived from the Calgary Birth Control Clinic," in Family Planning and Abortion Services, p. 45. Grauer, pp. 729-40; Sullivan and Watt, p. 83; Kazanjian, p. 8; Arnold, p. 100; Nancy Garrett, "Choosing Contraception According to Need," in Family Planning

in Canada: A Source Book, p. 146; Susan Watt, "Abortion: A Challenge for Social Work," in Family Planning in Canada: A Source Book, p. 219; Canadian Facts, vol. 3, p. 32; Elahi, pp. 517-18; Hunter, p. 1090.

<sup>53</sup>Sachdev, p. 171; Lipper, p. 854; Guyatt, in Family Planning in Canada: A Source Book, p. 177; Canadian Facts, An Assessment of the Mass Media Campaign for Family Planning, vol. 2 (Toronto: Canadian Facts Co. Ltd. 1973), p. 87.

<sup>54</sup>Meikle, p. 75.

<sup>55</sup>It may be noted that psychodynamically oriented theories still stubbornly persist which seek an explanation for an out-of-wedlock pregnancy in terms of some purposeful unconscious motivation and consequent responsiveness toward preventive devices. This perspective is outside the scope of this review, which will deal with the phenomenon as presented at conscious level, however hidden the motives.

<sup>56</sup>Sachdev, p. 186.

<sup>57</sup>David A. Claman, Barry J. Williams, and L. Wogan, "Reaction of Unmarried Girls to Pregnancy," The C.M.A. Journal (September 20, 1969): 5; Sachdev, p. 187.

<sup>58</sup>Charles E. Bowerman, Donald P. Irish, and Hollowell Pope, Unwed Motherhood: Personal and Social Consequences (Chapel Hill, North Carolina: University of North Carolina, Institute for Research in Social Science, 1963-66) p. 309; J.F. Kantner and Melvin Zelnik, "Contraception and Pregnancy: Experience of Young Unmarried Women in the United States," Family Planning Perspectives, 5 (Winter 1973): 22.

<sup>59</sup>Guyatt, in Family Planning in Canada: A Source Book, p. 177; Sachdev, p. 166; Canadian Facts, vol. 3 p. 32, Meikle, p. 44; Hunter, p. 1089; The Regina Family Planning Clinic Study, p. 74.

<sup>60</sup>Kazanjian, p. 8; Sachdev, p. 116; The Regina Family Planning Clinic Study, p. 74.

<sup>61</sup>Sachdev, p. 166, Belanger and Bradly, p. 21.

<sup>62</sup>Meikle, pp. 45, 75.

<sup>63</sup>Regina Family Planning Clinic Study, p. 75.

<sup>64</sup>Ottawa Citizen, July 8, 1974.

- <sup>65</sup>Elahi, Survey in Halifax, N.S., p. 519.
- <sup>66</sup>Hunter, p. 1089.
- <sup>67</sup>Pool, p. 79.
- <sup>68</sup>Paul Mackenzie, p. 764, Hunter, p. 1089, Balakrishnan, p. 7; Pool, p. 79, Regina Family Planning Clinic Study, p. 37 (Table 10); Arnold, et al., p. 79, Fran Innes, "Family Planning in Newfoundland" (speech delivered at the Provincial Family Planning and Sex Education Conference, St. John's, Nfld., May 11-12, 1973) p. 25. However, one study by the United Community Services of Greater Vancouver noted that male and female sterilizations were equally divided in their sample, Babies by Choice, Not by Chance p. 36.
- <sup>69</sup>Private Communication from Dr. S.C. Robinson, The Women's Clinic, Halifax, N.S., dated November 5, 1975.
- <sup>70</sup>Latif and Boldt, pp. 13-15; Regina Family Planning Clinic Study, p. 84.
- <sup>71</sup>Carl F. Grindstaff and G. Edward Ebanks, "Vasectomy: Canada's Newest Family Planning Method," Canada's Mental Health, 21 (September 1973): 5; United Community Services of Greater Vancouver, vol. I, p. 45.
- <sup>72</sup>Grindstaff and Ebanks, p. 5.
- <sup>73</sup>Evelyn E. Hartman, "A Look at the Family Planning Nurse Practitioner," Minnesota Medicine, 57 (February 1974): 139-41; Donald W. Freeman, "In-Hospital Post-partum Approach to Family Planning," Minnesota Medicine, 56 (1973) p. 46.
- <sup>74</sup>Allen G. Rosenfield, "Auxiliaries and Family Planning," Lancet (March 16, 1974): 443-45.
- <sup>75</sup>Cenovia Addy, "Birth Control in Canada: Five Years of Legitimacy," (paper read at the Ontario Conference on Birth Control and Sex Education, Toronto, Ontario, October 2, 1974); Bouma and Bouma, pp. 105-106.
- <sup>76</sup>Canadian Facts, vol. 1. pp. 62, 89.
- <sup>77</sup>Family Planning Association of Newfoundland and Labrador, "Attitudes Toward and Utilization of Family Planning Services in the city of St. John's," (1975), p. 43. (Mimeograph.)
- <sup>78</sup>"Regina Family Planning Clinic Study," p. 103.

- <sup>79</sup>Elahi, Survey in Halifax, N.S. p. 517.
- <sup>80</sup>United Community Services of the Greater Vancouver Area, vol. I, p. 57; Arnold et al., pp. 145-46; Pool, pp. 90-91.
- <sup>81</sup>Regina Family Planning Clinic Study, p. 121.
- <sup>82</sup>C.J.G. Mackenzie, G.P. Evans, and J.G. Peck, "The Vancouver Family Planning Clinic: A Case Study," Canadian Journal of Public Health, 5 (February 1967): 58.
- <sup>83</sup>Latif, and Boldt, working paper 3, pp. 3-6.
- <sup>84</sup>Paul Mackenzie, "Postpartum Family Planning Private Practice: A Baseline Study," Obstetrics and Gynecology, 44 (November 1974): 764.
- <sup>85</sup>"Regina Family Planning Clinic Study," p. 85.
- <sup>86</sup>Family Planning Association of Newfoundland and Labrador, p. 65; Elahi, Survey in Halifax, N.S. p. 517.
- <sup>87</sup>K.E. Belanger and Eleanor J. Bradley, "Family Planning and the Single University Student," Social Worker (February 1970): 19; Regina Family Planning Clinic Study, p. 70.
- <sup>88</sup>Guyatt, p. 177.
- <sup>89</sup>C.J.G. Mackenzie, "The Vancouver Family Planning Clinic, Comparison of Two Years Expense," Canadian of Public Health 54 (July 1968): 262-63.
- <sup>90</sup>"Regina Family Planning Clinic Study," pp. 9-11.
- <sup>91</sup>"Regina Family Planning Clinic Study," pp. 12-23.
- <sup>92</sup>United Community Services of the Greater Vancouver Area, vol. II, pp. 35-38.
- <sup>93</sup>Addy, "Birth Control in Canada, Five Years of Legitimacy," p. 17.
- <sup>94</sup>Donald W. Hastings, and George E. Provol, "Pharmacists' Attitudes and Practices Toward Contraceptives," Journal of the American Pharmaceutical Association No. 2. (1972): 76-81; Samuel Kalman, "The Pharmacist and The Family Planning," The Virginia Pharmacist (January 1973): 14-15; N.J. Rummel, L. Reich, C. Stringfeller and R.J. Pion, "The Pharmacist's Neglected Role," Family Planning Perspective, vol. 3, No. 4: 80-82.

<sup>95</sup>Private Communication from Dr. Carl F. Grindstaff, Department of Sociology, University of Western Ontario, London, dated August 14, 1975.

<sup>96</sup>Arnold, et al.; United Community Services of the Greater Vancouver Area, vols. I & II.

<sup>97</sup>For a detailed account of these experiments, see Gitta Meier, "Research and Action Programmes in Human Fertility Control: A Review of the Literature," in Family Planning: Readings and Case Materials, ed: Florence Haselkorn (New York: Council on Social Work Education, 1971), pp. 234-36.

<sup>98</sup>Two studies suggest that social workers have generally been loath in making referrals of families in need of birth control services: United Community Services of the Greater Vancouver Area, vol. II, p. iii; Kathleen Belanger, "Occupants Sleeping: Do Not Disturb, Dangerous When Aroused," The Social Worker (July 1971): 136-140.

<sup>99</sup>United Community Services of the Greater Vancouver Area, vol. I, p. iv; and Arnold, et al., pp. 22-23.

<sup>100</sup>The American Sociologist, Bogue cites encouraging results of similar experiments being tried in developing countries. See Donald J. Bogue, "The End of the Population Explosion," in Population, Environment and Social Organization: Current Issues in Human Ecology, ed: Michael Micklin (Hinsdale: the Dryden Press, 1973), pp. 347-348.

<sup>101</sup>A number of scholars stress the psychological and human factors that influence contraceptive behaviour. See, for instance, Michael J. Ball, "Obstacles to Progress in Family Planning," C.M.A. Journal, 106 (February 5, 1972,): 227-229; H. Philip Hepworth, Family Planning and Abortion Services and Family Life Education Programs (Ottawa: The Canadian Council on Social Development, Vol 5, 1975) p. 78. Reuben Hill, J.M. Stycos, and K. Buck, The Family and Population Control (Chapel Hill: University of North Carolina, 1959), p.66. Hill, et al. identify four essentials for the effective utilization of family planning means: intellectual facilitation, physical facilitation, psychological facilitation, and sociological facilitation.

For a fuller discussion of the socio-psychological variables believed to be associated with the degree of motivation affecting success at contraception, see A.H. Latif, Research into the Non-Medical Factors Affecting Contraceptive Practices of Women at Risk: A Contraceptual Scheme, working paper no. 1, Department of Sociology, Family Planning Research Project, University of Manitoba, Winnipeg.

102Gourgues; Meier, p. 229; Lee Rainwater, And the Poor Get Children (Chicago: Quadrangle Paperbacks, 1960).

103Donald W. Freeman, "In Hospital Postpartum Approach to Family Planning," Minnesota Medicine, vol. 56 (1973).

104The National Survey conducted by the Canadian Facts Co. also identified three groups -- immigrants, young people and lower income families -- that are considered to have the greatest need for family planning information. Canadian Facts, vol. 1, p. 2.

105It is understood that a national fertility survey is being planned by the Family Planning Division. See R.W. Tooley, "Family Planning in Canada," (a working paper presented at Alberta Conference, 1974), p. 15.

106A.H. Latif is presently conducting a study in Winnipeg using a case history approach to assess the roles of social, cultural, and psychological factors affecting motivation for initiation of contraception and their continued use. See Latif, working paper I.

107Albert Comanor, and Nicholas Zay, "Two Indicators of Gerontology Status in Canada: Gerontology in Social Work Curricula and Social Welfare Research in Gerontology," The Social Worker 40 (December 1972): 240.

## APPENDICES



TASK FORCE OF THE ASSOCIATION OF SOCIAL  
SERVICE CENTRES OF QUEBEC ON FAMILY PLANNING AND  
HUMAN SEXUALITY

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naissances du Canada

Rodrigue Blais  
Association des Centres de  
Services Sociaux du Québec.

TASK FORCE OF THE ASSOCIATION OF SOCIAL SERVICE CENTRES OF QUEBEC  
ON FAMILY PLANNING AND HUMAN SEXUALITY  
PSYCHOLOGICAL AND SOCIAL ASPECTS OF THE FOUR STAGES  
AN INDIVIDUAL GOES THROUGH IN FAMILY PLANNING  
A Guide for the use of the helping professions.

December 8, 1975

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3. Definition: Family Planning
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Main Factors to Investigate and Identify

... in Each of the Four Stages of "Planning" Behaviour

- Motivation
- Information
- Choice
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5. Note on the Use of the Guide for Identification and Intervention
6. When to Make a Referral for Psychosocial Counselling

PRELIMINARY REMARKS

This "guide" is a separate printing of a portion of the work by an ACSS task force on family planning and human sexuality, It is printed and distributed solely as a working paper, intended primarily for professionals and volunteers specializing in working

with family planning.

## INTRODUCTION

In our roles as practitioners of psychosocial assistance with family planning we have, on the basis of our experience, attempted to identify<sup>2</sup> the psychological and social aspects that are brought into play with any family planning behaviour, be it individual or that of a couple.

For analytical purposes we have distinguished between four major stages in this action: motivation, information, choice and perseverance<sup>2</sup>. And for each of these stages we have pointed out some of the aspects of psychological and social reality that intervene either favourably or unfavourably.

## PSYCHO-SOCIAL ASPECTS

It was our wish to make this body of reflections on these aspects accessible to those involved in family planning information or counselling. In this way we hope to give them some help both in identifying the psychosocial aspects of family planning and in giving them more attention in their professional practice, for these aspects are part of the day-to-day reality of any person who has taken the option of controlling his or her fertility.

A client who consults a physician for oral contraceptives has already taken certain steps influenced by her personal aspirations, her social situation, her environment, her values. She has chosen either not to have a child for the moment or not

to have one at all; she has had to seek information and make the choice that suits her. After that she must apply that method daily. In the time perspective, then, the visit to the physician seems very fleeting despite its importance, compared to all that this person has experienced before and will experience afterwards.

Family planning behaviour is therefore not an isolated gesture in time, but rather, generally, part of the affective, rational and ideological stuff from which the individual or couple is made, and it is expressed by a number of options; to have children or not, choice of the number and timing of pregnancies, limiting or spacing, and so on. When these options of behaviours are less free or less satisfactory because of unfavourable psychosocial factors, it is important that "family planning agents" find the means of intervention that are the most likely to favour acquisition of self-actualizing "planning" behaviour.

#### GUIDE FOR IDENTIFICATION AND INTERVENTION

So that we would remain close to our experience and that of the various professionals and volunteers involved in family planning, we have avoided long theorizing on the psychosocial aspects of family planning. We are presenting them here in the form of a "guide" schematizing certain psychosocial dimensions facilitating or hindering family planning behaviour and certain orientations that should be taken at the level of

the helping relationship.

The proposed grid is not an exhaustive enumeration of all the possible aspects; instead it illustrates the various psychological and social aspects that act on family planning behaviour. To avoid needless repetition we have pinpointed only those elements that seems to us the most specific and definitive with regard to a given stage: thus encouragement by friends will be given as a social element with regard to motivation, but will not be mentioned in connection with the choice of method (although it does also affect that choice).

Methodological indications contained in the grid are also of necessity limited and specific to the situation illustrated. Their intention, therefore, is not to tell the reader how to conduct an interview, since we take it for granted that any family planning agent knows how to conduct a helping relationship taking into consideration the basic principles of a helping interview and respecting the person involved. We take for granted also that these same agents will make referrals to specialized resources when the psychological and social elements identified in the interview go beyond the objectives of family planning.

#### QUESTIONS COVERED

This guide does not take a stand on the following methodological question: should interviews be of the "evaluative" or "non-evaluative" type, that is, should they evaluate or encourage

self-determination?

Without rejection of the evaluative and recommendatory approach that is sometimes necessary in certain specific situations (for example with persons of limited intelligence or mental handicaps,) it is our general belief that we must allow and encourage freedom of choice. The principle of self-determination appears basic in a field as personal as contraception and we must recall here that social service has made it one of the basic rules of its discipline.

It must be kept in mind, however, that the right to self-determination is subject to the present state of imperfection of contraceptive means, the state of medical knowledge, and socioeconomic conditioning.

We also wish to point out that the proposed grid, although it presents methodological indications intended for those in the helping professions, is not excluded from use by the client himself. It is our belief, in fact, that such a grid with adaptations could eventually serve as a tool for self-evaluation.

This same grid has considered contraceptive behaviour as involving the individual first of all. We would like to round it out later with a document covering the intervention to be carried out at the community level.

## DEFINITION OF FAMILY PLANNING

In current literature and language there are various definitions and labels for involvement in human reproduction.

We have chosen the term "family planning," to which we assign the following content:

Family Planning is the action by which:

(a) The individual or couple decides on the number of children desired and the timing and circumstances of their birth;

(b) The individual or couple uses the methods chosen while pursuing sexual self-actualization.

This action is also involved in cases of infertility or low fertility.

This definition implies:

(a) For the individual or couple, the right to have children or not to have children;

(b) For the child, the right to be born in favourable conditions

(c) For society, the duty to provide adequate services in the areas of contraception and fertility.

FOUR STAGES IN FAMILY PLANNING BEHAVIOUR:

MOTIVATION

INFORMATION

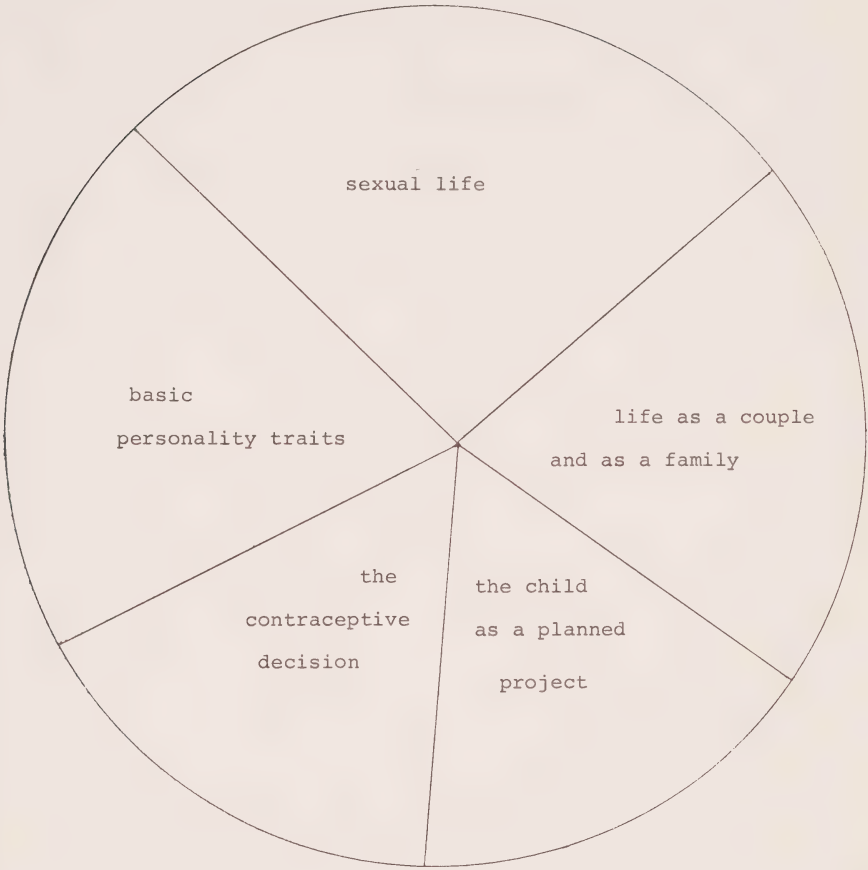
CHOICE

PERSEVERANCE

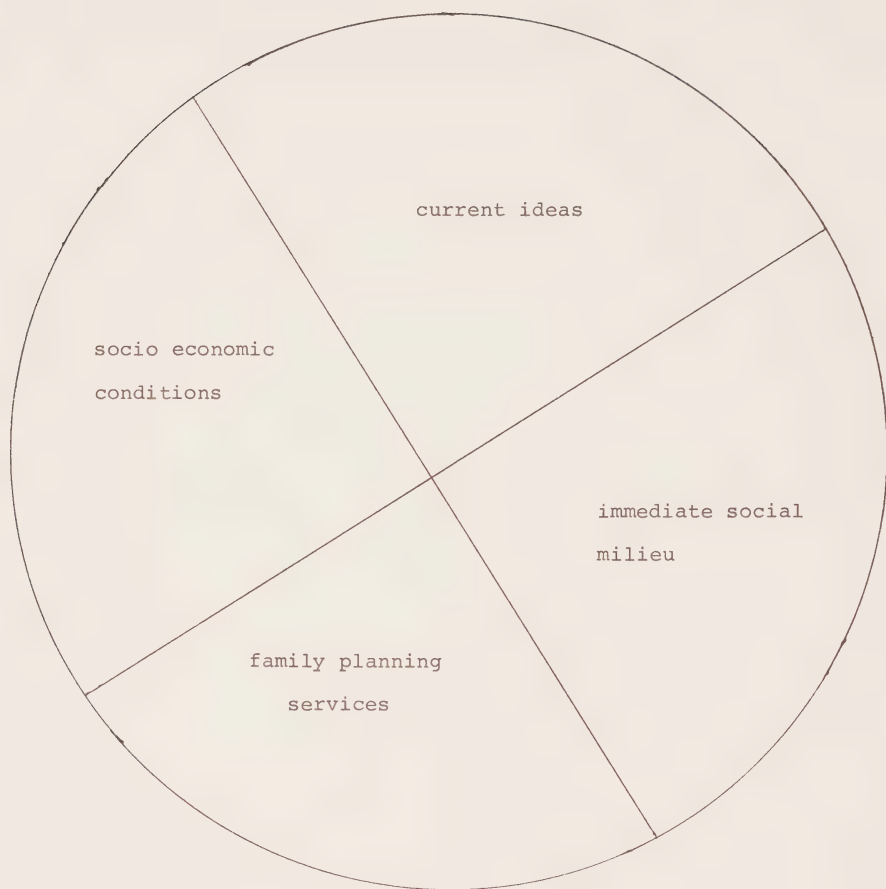
AND THEIR PSYCHO-SOCIAL ASPECTS



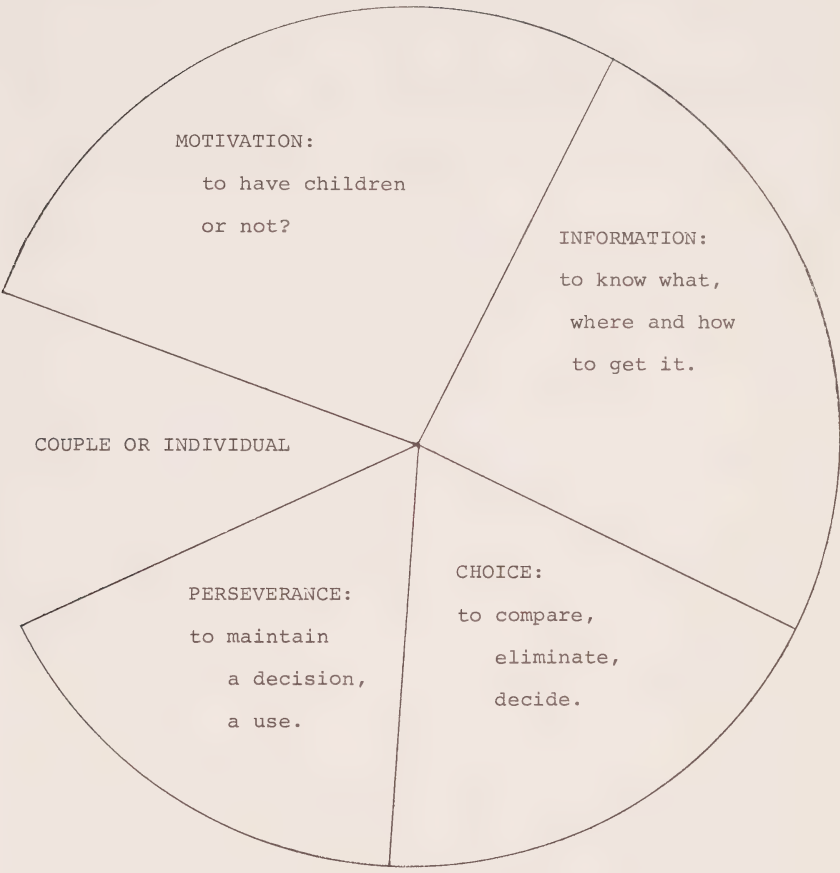
MAIN FACTORS TO INVESTIGATE  
AND IDENTIFY



PSYCHOSOCIAL ASPECTS



• • • IN EACH OF THE  
FOUR STAGES OF  
"PLANNING" BEHAVIOUR



## MOTIVATION

By family planning motivation we mean the awareness of the various psychological, economic, social and ideological factors that move the individual to face up to his fertility and adopt a "planning" behaviour.

Favourable Psychological Aspects

PSYCHOLOGICAL ASPECTS

- 1) DESIRE TO ACQUIRE OR MAINTAIN RESPONSIBLE ATTITUDES TOWARDS SEXUALITY AND THE CONCEPTION OF A CHILD

ILLUSTRATIONS OR EXPLANATIONS

- 1) Sustained desire as a result of:  
-Adequate knowledge of sexual functions and the physiological implications of an active sexual life.  
-Perception of the rights and needs of the child.  
-The decision to make oneself available to each member of the family.

METHODOLOGICAL INDICATIONS FOR THE HELPING RELATIONSHIP

- 1) -Sustain this desire for responsibility and autonomy.  
-Take the time to round off information on biology.  
-Put oneself in the place of the children already born.  
-Find out the contraceptive motivation of the spouse/partner.

- 2) TEMPORARY OR DEFINITIVE WISH TO AVOID A PREGNANCY.

- 2)-Feeling of still needing some time before having a child or another child.

- Fear of the psychological difficulties that might result from a pregnancy not wanted by the parent and/or rest of the family.  
-Poor acceptance of the role of procreator.  
-Feeling of having reaching one's limits as a parent.

- Difficulty in accepting a child's state of dependency and the restraints connected with this.

- 2) -Clarify what is seen as an obstacle and the reactions that accompany it.  
-Situate this element as a variable along with the others.  
-Mention the possibility of psychosocial consultation and provide for follow-up.

- 3) WORRIES OR FEARS BASED ON BAD  
MEMORIES OF PREGNANCY,  
DELIVERY, HOSPITALIZATION,  
CHILD CARE, ATTITUDES OF  
THE SPOUSE OR HER OWN  
REACTIONS
- 3)-These fears occur in many  
women.  
-Period of "post-partum  
depression"
- 3) -De-dramatize the situation  
and find out what is  
creating the difficulty and why.  
-Give information on post-  
partum period.  
-Refer to other specialists  
if needed.

Favourable Social Aspects

SOCIAL ASPECTS

ILLUSTRATIONS AND EXPLANATIONS

METHODOLOGICAL INDICATIONS FOR  
THE HELPING RELATIONSHIP

1) SUPPORT AND ENCOURAGEMENT BY  
THE SOCIAL MILIEU FOR FAMILY  
PLANNING

1) The feeling of being supported  
by one's surroundings (parents,  
friends, associations etc) is  
a comforting one and reinforces  
individual motivation.

2) DISAPPROVING ATTITUDES IN RELATION  
TO PREGNANCIES SEEN AS IRRESPONSIBLE

2) The feeling that there is public  
disapproval of teen-ager pregnancies,  
pregnancies among the physically  
and mentally handicapped, the  
unmarried, is sometimes a motiva-  
ting factor.

2) Help the person express  
himself

- Reinforce his critical  
faculty and autonomy.
- Orient towards a more positive  
motivation.

3) FAMILY, ECONOMIC AND SOCIAL  
CONDITIONS OBLIGING FAMILY PLANNING

3) Certain conditions seen as major  
obstacles to having another child:  
low income, small living quarters,  
spouse's working conditions, wife's  
state of health, health of husband  
and children.

3) Properly identify what  
conditions represent the most  
restraints and how they are  
seen.

4) CREDIBILITY OF ORGANIZATIONS AND  
INDIVIDUALS PROVIDING FAMILY PLANNING  
SERVICES

4) The service given by individuals  
and organizations have a certain  
moral guarantee, as in "if the  
government is behind the service,  
it must be good."

4) Identify what this confidence  
is based on and give  
additional objective  
information if necessary.



Unfavourable Psychological Aspects

<u>PSYCHOLOGICAL ASPECTS</u>	<u>ILLUSTRATIONS OR EXPLANATIONS</u>	<u>METHODOLOGICAL INDICATIONS FOR THE HELPING RELATIONSHIP</u>
1) INABILITY OR DIFFICULTY IN ASSUMING RESPONSIBILITY REGARDING SEXUALITY AND CONTRACEPTION	1) -This can be connected with a habitual inability to make decisions, a feeling or personal insecurity, mental deficiency, a drug problem etc. -Lack of concern for the eventual consequences of an unwanted pregnancy.	1) -Encourage open expression of these fears and difficulties. -Offer counselling (short term) either individually or in groups. -Make an "imaginative" effort to deal with the specific social problems.
2) AMBIVALENCE REGARDING FAMILY PLANNING AND FAMILY PLANNING METHODS	2) -Perception of the child as a proof of virility, femininity, youth (for example in the period preceding menopause). -Incomplete knowledge of methods and one's own physiological functions. -Fear of impotence as a result of use of a contraceptive. -Non-acceptance of constraints related to the methods. -Sensitivity to pressure from other children for another child ("a little sister"; "I never have anyone to play with.")	2) -Help the client to express him/herself on this ambivalence and try to clarify it together. -Put on the follow-up list. -In certain cases, offer to include children and spouse/partner in the interviews.

3) PERIOD OF STRESS, EMOTIONAL  
CRISIS, GREAT ANXIETY

- 3) -Attitude of temporary abandonment  
of contraception due to marital  
conflict, loss or illness of a  
family member etc.
- 3) -Express empathy and offer  
further interviews.

Unfavourable Social Aspects

SOCIAL ASPECTS

ILLUSTRATIONS OR EXPLANATIONS

METHODOLOGICAL INDICATIONS FOR  
THE HELPING RELATIONSHIP

1) WAYS OF THINKING THAT ARE  
SOMEWHAT UNFAVOURABLE TO  
FAMILY PLANNING BEHAVIOUR

- 1) -Value attached to having a large number of children without any precise plan for spacing them.
- Religious and moral scruples regarding family planning.
- Resistance to acceptance of an active sexual life for the unmarried, the teen-ager, the woman on her own.

- 1) Help the person to clarify needs and expectations and then to make a personal choice.

2) UNFAVOURABLE PREJUDICES  
RELATED TO THE ORGANIZATION  
THAT IS ENDORSING OR  
RECOMMENDING FAMILY PLANNING

- 2) -Social services centre identified with welfare...
- Words such as sexology, sexuality, sex alarm many people.
- Obligation for consultation for a sterilization or abortion without much understanding of the reason why.

- 2) Allow the expression of these prejudices and bring about correction of or alteration in them.

3) SOCIOECONOMIC FACTORS  
UNFAVOURABLE TO MOTIVATION

- 3) -Sexual promiscuity.
- Difficult access to services.
- Demeaning work.
- Cultural poverty.

- 3) Consider the environment of the individual, his primary education, his degree of comprehension.

-Verify the true impact of these elements on the individual.

- |  |  |
|--|--|
| <p>4) PERSONAL RESISTANCE TO THOSE WITH THE INFORMATION AND TO THE IDEA OF COUNSELLING REGARDING FAMILY PLANNING</p> | <p>4) -A more-or-less veiled rejection of the client's request, for example in the case of teen-agers or when it concerns sterilization or abortion.</p>                           |
|  | <p>4) Encourage an agreeable atmosphere so that people can feel at ease. Develop an attitude of acceptance, giving those coming for counselling sufficient time and attention.</p> |

## INFORMATION

By information we mean those attitudes and actions through which the individual or couple seeks or gathers information that is both objective and adapted to the situation on the methods and services that are available in the area of contraception and fertility.

# INFORMATION

## Favourable Psychological Aspects

### PSYCHOLOGICAL ASPECTS

#### 1) CLEAR MOTIVATION TO PLAN

- 1) -A well-motivated person is immediately open to accept precise information.

#### 2) ACCEPTANCE OF SELF AS SEXUALLY ACTIVE OR POTENTIALLY SO

- 2) -To the extent that this acceptance exists, the fact that one is seeking information on methods does not lead to embarrassment.

#### 3) CAPACITY AND READINESS TO RECEIVE INFORMATION FROM SOMEONE ELSE

- 3) -For some people this readiness means: accepting that it is all right not to know everything and asking precise questions.

#### 4) CONFIDENCE WITH REGARD TO INFORMATION AND THE PERSON OR INDIVIDUAL PROVIDING IT

- 4) -A feeling that one's preoccupations have been so well dealt with that the person providing the information is no longer seen as a propagandist trying to put something over on you.

### METHODOLOGICAL INDICATIONS FOR

#### THE HELPING RELATIONSHIP

- 1) -Before launching into detailed information, probe to see whether motivation to plan conceptions is sufficiently clear and untroubled.

- 3) -Know how to adapt the information to the intellectual level of the person seeking it and his concrete situation.

- 4) -Maintain and reinforce this confidence through honesty; sure and complete explanations, use of properly prepared means of information, recognition of one's limitations.

Favourable Social Aspects

<u>SOCIAL ASPECTS</u>	<u>ILLUSTRATIONS OR EXPLANATIONS</u>	<u>METHODOLOGICAL INDICATIONS FOR THE HELPING RELATIONSHIP</u>
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- |  |  |   |
|--|--|---|
| 1) EXISTENCE OF WELL-IDENTIFIED<br>PLANNING SERVICES, PHYSICALLY<br>AND PSYCHOLOGICALLY ACCESSIBLE     | 1) -Information seems to be accepted<br>better if it is given and adapted<br>to homogeneous groups, adolescents,<br>young couples, physically handi-<br>capped, mentally handicapped etc.<br>-Services open evenings are more<br>accessible. | 1) -Inform client of other sources of<br>information, in the knowledge<br>that peer information is often<br>better integrated and used. |
| 2) ACCEPTANCE BY THE GROUP OF FREE<br>CIRCULATION OF INFORMATION ON<br>SEXUALITY AND FERTILITY CONTROL | 2) -Sexuality is then seen as a subject<br>that can be discussed calmly with more<br>objective information.  |   |
| 3) EXISTENCE AND DISTRIBUTION OF<br>ACCESSIBLE AND HIGH QUALITY<br>MEANS OF INFORMATION                | 3) -For example, the written word<br>reinforces memory, calms doubts, helps<br>with decision-making.   | 3) -Supply a text of good quality,<br>clear and understandable, for<br>information.   |

# INFORMATION

## Unfavourable Psychological Aspects

### METHODOLOGICAL INDICATIONS FOR THE HELPING RELATIONSHIP

## ILLUSTRATIONS OR EXPLANATIONS

## PSYCHOLOGICAL ASPECTS

- |  |  |   |
|--|--|---|
| <p>1) INCONSISTENT MOTIVATION TO PLAN FERTILITY</p>  | <p>1) -Ambivalence toward planning and its methods.<br/>-Periods of stress, emotional crisis, great anxiety.</p>   | <p>1) -Create a relaxed atmosphere, do away with the anxiety that may be accentuated by having to ask for information.</p>  |
| <p>2) RESISTANCE TO GOING BEYOND A SIMPLE STATEMENT OF ONE'S INTENTION TO DO SOMETHING ABOUT BIRTH CONTROL</p> | <p>2) -Low or inconsistent motivation.<br/>-The fact that one is seeking precise information may revise more-or-less explicit fears: the fear that one is indirectly admitting to sexual activity, the fear of losing spontaneity or bodily integrity.</p> | <p>2) -Take the time to explore hesitations and fears.</p>  |
| <p>3) INABILITY OR LACK OF READINESS TO RECEIVE INFORMATION</p>  | <p>3) -A feeling of having heard it all before.<br/>-Resistance to being given information from a specialist, lack of confidence.<br/>-Feeling of being limited intellectually.</p>  | <p>3) -Take the trouble to try out various ways of presenting information (refresh our memories") and do away with prejudice that it has all been heard before.<br/>-Adapt to intellectual capacities: patience and imagination.<br/>-Present the service as not limited to one</p> |



SOCIAL ASPECTS

ILLUSTRATIONS OR EXPLANATIONS

METHODOLOGICAL INDICATIONS FOR THE  
HELPING RELATIONSHIP

- |   |  |   |   |
|---|--|---|---|
| 1) SERVICES NOT HIGHLY ACCESSIBLE<br>OR WITH NO IMPACT ON ATTITUDES<br>OR BEHAVIOUR     | 1) -Impression that one is not<br>concerned by the information<br>given out by the services.   | 2) -Find out how these contradictions<br>(or absence of group support) are<br>concretely experienced.<br>-Reinforce self-determination.<br>-Provide services that are not<br>limited by ideologies. | 3) -Give exact information that is to<br>the point, emphasize the existence<br>of other sources of information. |
| 2) CONTRADICTORY ATTITUDES<br>REGARDING SEXUALITY AND<br>TENDENCY TO RADICALIZE OPINION | 2) -Permissiveness, unqualified and<br>without sense of responsibility.<br>-Repression of all sexual behaviour<br>that is marginal compared to the<br>standards of traditional morality.<br>-Impression that one ought to fit<br>into one camp or the other. |   |   |
| 3) EXISTENCE OF CULTURAL STEREO-<br>TYPES WITH REGARD TO "INFORMA-<br>TION AGENTS"      | 3) -These stereotypes limit confidence<br>to only a few people: "the parish<br>priest is objective", "the doctor<br>knows that", "the doctor doesn't<br>bother with such things," etc.   |   |   |

- 4) MULTIPLICITY OF SLOGANS' QUICK  
AND OFTEN CONTRADICTORY INFOR-  
MATION ON SEXUALITY AND  
CONTRACEPTION.
- 4) -Oversaturation and confusion of  
messages.  
-Hostility due to having been given  
false or incomplete information, or  
information with an ideological  
slant.
- 4) -Help the client to verbalize  
this feeling of saturation and  
hostility.  
-Work from this distrust.  
-Answer personal questions.

## CHOICE

By choice we mean the decision-making by which the individual or couple determine the method that seems best suited to their "planning" behaviour.

CHOICEUnfavourable Social AspectsPSYCHOLOGICAL ASPECTSILLUSTRATIONS OR EXPLANATIONSMETHODOLOGICAL INDICATIONS FOR  
THE HELPING RELATIONSHIP

1) MOTIVATION FOR FAMILY PLANNING  
SUSTAINED BY EXACT KNOWLEDGE OF  
METHODS AND CAPACITY TO ACT IN  
CONSEQUENCE OF THIS MOTIVATION

1) -The choice of method is facilitated  
by an absence of prejudice with  
regard to the total spectrum of  
methods and also by an ability to  
pinpoint and carry out a personal  
or joint plan.

1) -Identify this capacity and  
offer counselling tailored to it.

2) CAPACITY TO PERCEIVE AND TAKE  
INTO ACCOUNT THE FACTORS OF  
REALITY THAT CONDITION THE  
CHOICE OF A GIVEN METHOD

2) -Examples of the reality: medical  
counter-indications, socioeconomic  
indications, high-risk pregnancies  
requiring reliable methods, some  
plan as a couple that fits in better  
with less sure methods etc.

2) -Seek together the method that  
best suits the reality of the  
client.  
-Analyze together the definitive  
or temporary character of the  
method chosen (and its  
psychological impact).

3) ACCEPTANCE OF THE CONSTRAINTS  
RELATED TO EACH METHOD

3) -Each method carries with it certain  
constraints:  
Partner's co-operation is necessary;  
Regularity of the method (sympto-  
thermal);  
Presence of a foreign body.

(cf. description of the constraints  
that go with each method)

- |  |  |   |
|--|--|---|
| 4) CONTRACEPTION SEEN AND EXPERI-<br>ENCED AS A FACTOR IN SEXUAL-<br>ACTUALIZATION | 4) -No longer any fears of pregnancy in a<br>sexual relationship.<br>-Peace of mind through use of a method. | 4) -Build up this aspect and<br>recall it to mind, especially<br>with teen-agers. |
|--|--|---|

Favourable Social AspectsPSYCHOLOGICAL ASPECTSILLUSTRATIONS OR EXPLANATIONSMETHODOLOGICAL INDICATIONS FOR  
THE HELPING RELATIONSHIP

- |  |   |  |
|--|---|--|
| <p>1) DEVELOPMENT OF TRENDS OF THOUGHT THAT RECOGNIZE THE SPOUSE OR PARTNER'S RESPONSIBILITY FOR CONTRACEPTION</p> | <p>1) -This shared responsibility makes for a greater choice of methods; with either one or the other partner assuming responsibility for a certain period of time or the one partner feeling supported by the other in putting up with the constraints of the method chosen.</p> | <p>1) -Offer the possibility of a joint interview (without making it a systematic rule).<br/>-Present family planning (and services) as an action that involves both the man and the woman.<br/>-Find out the feelings about contraception held by the "second party."</p> |
| <p>2) LIVING CONDITIONS FAVOURABLE TO ACCEPTANCE OF CONSTRAINTS RELATED TO USE OF THE METHODS</p>                  | <p>2) -Stability of the relationship, regular and stable presence of partners, income and housing.</p>  | <p>2) -Draw attention to the daily actions required by the method chosen.</p>  |
| <p>3) AVAILABILITY AND ACCESSIBILITY OF SERVICES AND OBJECTIVITY TO THE WHOLE RANGE OF METHODS</p>                 | <p>3) -Presence of clinics, pharmacists; acceptability of these services.</p>   |  |
| <p>4) ACCEPTANCE OF ALL METHODS BY ASSOCIATES AND SOCIETY</p>  | <p>4) -For example, a couple seeking sterilization will opt for vasectomy more easily if this has been consistently presented as of no danger to virility.</p>  |  |

Unfavourable Psychological Aspects

PSYCHOLOGICAL ASPECTS

ILLUSTRATIONS OR EXPLANATIONS

METHODOLOGICAL INDICATIONS FOR  
THE HELPING RELATIONSHIP

1) INCONSISTENT CONTRACEPTIVE  
MOTIVATION NOT SUSTAINED BY  
COMPLETE KNOWLEDGE OF  
CONTRACEPTION

- 1) -Ambivalence concerning desire for a child.
- Inconsistency regarding method chosen.
- Resistance to an active sexual life, for example: teen-agers, the unmarried, those living alone.

- 1) -Again clarify the questions of motivation and knowledge.

2) PERSONALITY FACTORS MAKING USE  
OF CERTAIN METHODS DIFFICULT OR  
IMPOSSIBLE

- 2) -Illiteracy, intellectual limitations, retardation and other problems, alcoholism, other addictions, psychological instability, passive-masochistic dependent personality, self-destructive tendencies, inability to follow through, impulsiveness, lack of maturity.

- 2) -Put on a follow-up list:  
Seek out teaching methods to reach these persons better;  
Create a proper environment;  
Work as a team with specialized resources.

3) PRECARIOUS MARITAL OR SEXUAL TIES  
SEEN AS BEING INCOMPATIBLE WITH  
USE OF CERTAIN METHODS (LONG-TERM)

- 3) -Marital crisis; sex as a bargaining instrument, separations, unaccepted extramarital relationships.

- 3) -Offer to refer to specialized consultation.  
-Put on a follow-up list.

4) STATE OF DEPENDENCY ON  
EVALUATIONS OR PRESSURE FROM  
FRIENDS AND RELATIVES WITH  
REGARD TO A GIVEN METHOD

- 4) -Excessive conditioning from others,  
inability to voice a personal  
choice or choice as a couple, need  
to conform with friends' fertility,  
fear of being an outsider.

- 4) -Encourage greater autonomy.  
-Offer a series of interviews  
(short-term).



## CHOICE

### Unfavourable Social Aspects

#### METHODOLOGICAL INDICATIONS FOR THE HELPING RELATIONSHIP

#### ILLUSTRATIONS AND EXPLANATIONS

#### SOCIAL ASPECTS

- |  |   |   |
|--|---|---|
| <p>1) <b>CONDITIONING AND SOCIAL PRESSURES<br/>BLOCKING PURSUIT OF INTENTIONS<br/>TO PLAN</b></p>                              | <p>1) Incomplete information spread in the mass media, various facts, gossip, hard-sell advertising.<br/>-Pressure from parents and friends, living with parents, remarriage, living conditions, requirements of job, prejudices, general experience.</p> | <p>1) -Facilitate self-determination and critical faculty.<br/>-Suggest the person get specific medical advice from the doctor.</p> |
| <p>2) <b>SOCIO-CULTURAL ENCOURAGEMENT<br/>TO HAVE MORE THAN AN "ONLY"<br/>CHILD AND TO HAVE CHILDREN<br/>OF BOTH SEXES</b></p> | <p>2) Belief that a child develops better along with other children ("I'll quit when I get a girl," desire to have an "heir" and "continue the line").</p>  | <p>2) -Facilitate self-determination.</p>   |
| <p>3) <b>INADEQUATE PLANNING SERVICES</b></p>  | <p>3) -Inadequate service providing little help in the choice of method:<br/>Incomplete and biased information, Certain methods presented as inaccessible;<br/>Services reserved for privileged customers<br/>Etc.</p>                                    |   |

## P E R S E V E R A N C E

By perseverance we mean:

- a) Maintenance of the decision to plan a family, by whatever method;
- b) Continuity in the use of the method chosen.

## PERSEVERANCE

### Favourable Psychological Aspects

#### METHODOLOGICAL INDICATIONS FOR THE HELPING RELATIONSHIP

#### ILLUSTRATIONS OR EXPLANATIONS

#### PSYCHOLOGICAL ASPECTS

- |   |  |  |
|---|--|--|
| <p>1) SATISFACTION WITH THE METHOD<br/>OF CONTRACEPTION CHOSEN AND<br/>THE ABILITY TO ACCEPT THE<br/>CONSTRAINTS IT IMPOSES</p>                     | <p>1) -The objectives of family planning<br/>are properly attained.<br/>-Unwanted pregnancies are avoided.<br/>-Accomplishment of personal aspirations<br/>and those as a couple is facilitated<br/>(career aspirations, those for welfare<br/>of the family, community involvement).<br/>-A quality of self-discipline and<br/>autonomy. (cf. description of<br/>constraints for each method)</p> | <p>1) Find out how satisfied the<br/>client is with the method used.</p>       |
| <p>2) MAINTENANCE OR IMPROVEMENT OF<br/>SATISFACTION IN ONE'S SEXUALITY</p>   | <p>3) -Maternal depression, poor physical<br/>condition.<br/>-Hostility, infidelity, abandonment<br/>by spouse.</p>  | <p>2) Enquire after repercussions of<br/>the method chosen on sexual life.</p> |
| <p>3) FEAR OF REPEATING A PREVIOUS BAD<br/>EXPERIENCE WITH A PREGNANCY THAT<br/>WAS DIFFICULT FOR THE MOTHER,<br/>AND/OR COUPLE AND/OR CHILDREN</p> | <p>3) -De-dramatize the previous<br/>experience and develop more<br/>positive motivations for family<br/>planning (individual or group<br/>interviews).</p>  |  |

4) FEELING OF BEING SUPPORTED BY  
SPOUSE

4) -Inconveniences of the contraceptive means are better accepted if the spouse or partner is also ready to accept his share of responsibility for contraception.

4) Find out the attitude of the spouse or partner.

## PERSEVERANCE

### Favourable Social Aspects

## METHODOLOGICAL INDICATIONS FOR THE HELPING RELATIONSHIP

### ILLUSTRATIONS OR EXPLANATIONS

#### SOCIAL ASPECTS

- |  |   |
|--|---|
| <p>1) PHYSICAL ACCESSIBILITY AND PSYCHOLOGICAL ACCESSIBILITY OF CONTRACEPTIVE SERVICES AND MEANS</p> <p>1) -Ease in procuring contraceptive means: free services, anonymity.<br/>-Possibility of obtaining medical or psychosocial consultation fairly quickly.<br/>-Open attitude of helping professions involved.</p> <p>2) REINFORCEMENT OF CONTRACEPTIVE BEHAVIOUR BY THE IMMEDIATE CIRCLE OR ALL OF SOCIETY</p> <p>2) -Certain trends of thought encourage contraception.<br/>-Emergence of social models that are restrictive regarding size of family: e.g. that of the two-child family.<br/>-Disapproval of family or friends re another pregnancy.</p> <p>3) SOCIO-ECONOMIC CONDITIONS ENCOURAGING PROPER CONTINUANCE OF CONTRACEPTIVE BEHAVIOUR</p> <p>3) Various conditions may reinforce this behaviour: budget, housing or health problems (physical or psychological), marital problems, working situation, personal ambition, plans for study etc.</p> | <p>2) -Reinforce autonomy and critical faculty in the face of social pressures.</p> <p>3) -Clarify motivation of planning.<br/>-If aspirations for fertility are not met, help the emotions be expressed and, if needed, make referral to specialized services.</p> |
|--|---|

PERSEVERANCEUnfavourable Psychological AspectsPSYCHOLOGICAL ASPECTSILLUSTRATIONS OR EXPLANATIONS

- 1) DIFFICULTIES THAT MUST BE PUT UP WITH RELATED TO CONSTRAINTS OF THE METHOD CHOSEN

- 1) -Inadequate evaluation of the constraints related to the method when choice was made.  
-Overestimation of capacity for self-discipline.

- 2) PSYCHOLOGICAL INTOLERANCE OF THE SECONDARY EFFECTS OF THE METHOD CHOSEN

- 2) -Refusal to adjust to, or inability to put up any longer with, certain secondary effects no matter what the seriousness of them: headaches, vaginal infection, weight gain, painful breasts, decrease in menstrual flow.

- 3) UNCONSCIOUS AMBIVALENCE ABOUT HAVING A CHILD

- 3) Fertility built up as a symbol of virility or femininity.  
-Feeling that a child may fill an emotional void.  
-Sensitivity to arguments of other children in favour of a new baby.

METHODOLOGICAL INDICATIONS FOR THE HELPING RELATIONSHIP

- 1) -Make a better evaluation with this person of the inconveniences, large and small; point out connections with everyday reality, the immediate environment, sexual relations.  
-Recommend a medical consultation.  
-Offer psychosocial counselling.  
-Develop a group approach if possible with other clients in the same situation.  
-Facilitate total support by the spouse/partner.
- 3) -Clarify and reinforce where needed the patient's personal aspirations regarding fertility.  
-Refer to specialized resources if need be.  
-Put on a follow-up list.

#### 4) PSYCHOLOGICAL DIFFICULTIES OR DISTURBANCES

- 4) Self-destructive tendencies, immaturity, 4) -Calm the anxiety, try to identify the difficulties being experienced:
  - Refer to specialized resources.
  - Put on the follow-up list.
  - Give the information again with adapted methods.
- irresponsibility, mental illness.
- retardation, alcoholism, inability to discipline self, delinquency, severe nervousness.
- Increased depression.
- Tendency to operate by "magical thinking."
- Serious emotional crisis as a result of illness, death, bankruptcy, divorce.
- Difficulty in developing personal plans.
- Embarrassment in seeking out contraceptive means.
- Intellectual or psychological problems with integration of information.
- Need to have someone dependent on oneself.

#### 5) PSYCHO-SEXUAL DIFFICULTIES

- 5) -Feeling ill at ease in the exercise of one's sexuality.
- Sexual dysfunction, frigidity, partial impotence, diminished libido.
- 5) -Assist the person in measuring the impact of this element on contraceptive behaviour; try to avoid having sexual self-actualization losing out to successful contraception.
- Offer specialized referral (in sexology for example).
- Put on a follow-up list.

PERSEVERANCEUnfavourable Social AspectsSOCIAL ASPECTSILLUSTRATIONS OR EXPLANATIONSMETHODOLOGICAL INDICATIONS ON THE  
HELPING RELATIONSHIP

- |  |   |  |
|--|---|--|
| 1) TRENDS OF THOUGHT UNFAVOURABLE<br>TO ONE OR ANOTHER METHOD                      | 1) -Newspaper campaigns against a method<br>or methods create anxiety.<br>-Privileged status assigned to<br>motherhood or fatherhood of large<br>families leads some persons to<br>totally cease any contraception.<br>-Certain religious, moral, ideological<br>values (such as naturalism) do not<br>encourage family planning. | 1) -Reinforce the personal autonomy<br>of the client against social<br>pressures.<br>-Develop a teaching approach that<br>will take into consideration the<br>values of a given society. |
| 2) DIFFICULTIES OF ACCESS TO<br>FAMILY PLANNING SERVICES<br>OR INADEQUATE SERVICES |   | 2) -Point out the various local of<br>regional resources (having<br>prepared a list beforehand).   |
| 3) SOCIO-ECONOMIC CONDITIONS<br>BLOCKING CONTINUANCE OF A<br>CONTRACEPTIVE METHOD  | 3) -The unstable or occasional character<br>of sexual relations: for example,<br>in the case of teen-agers, adults<br>without stable partners, couples<br>where one spouse's work often takes<br>him away from home.  | 3) -Try to find together the best<br>suited method for the conditions.   |



Probability of a breaking off of  
the relationship: divorce, separation.  
-Disorganized household due to  
overcrowding.  
-Cost of contraceptives.

NOTES ON THE USE OF THE GRID  
FOR IDENTIFICATION AND ACTION

- For the motivation and information stages the grid is also applicable to situations of infertility and low fertility.
- The list of psychosocial aspects and methodological indications is not exhaustive; each worker is invited to round them out from his or her own practice.
- As far as choice is concerned, there is always the fear of forgetting: a poor method is better than no method; the best method is always the one that the client will accept.
- Perseverance is not simply a result of the quality of the preceding stages; it is a stage by itself with its own characteristics and difficulties.
- The irreversibility of a method does not guarantee perseverance in the feeling of satisfaction with that method.

## WHEN TO MAKE A REFERRAL FOR PSYCHOSOCIAL COUNSELLING

### LIST OF INDICATIONS FOR PSYCHOSOCIAL CONSULTATION, EITHER INDIVIDUALLY OR IN A GROUP

This list is not all-inclusive. It has been drawn up for the use of family planning agents, both medical and social, both professional and volunteer, to help them better identify those situations requiring the assistance of a helping professional and to assist them in referral:

- in answer to a need for clarification on the decision to have a child or not;
- after an induced abortion;
- for young teen-agers;
- in the presence of secondary effects with no medical cause or those poorly tolerated psychologically;
- when a pregnancy would mean serious risks of all sorts;
- when planning motivation is uncertain;
- when the information has to be adapted specifically to those being given it;
- when a person has had the method of choice refused;
- when choice of a method seems difficult;
- when the contraceptive used has a negative effect on sexual life.
- when certain social problems made family planning difficult: rape, incest, alcoholism, drug addiction, retardation, isolation etc.

## FOOTNOTES

<sup>1</sup>Within the framework of a psychosocial committee on family planning and human sexuality created by the Association des Centres de Services Sociaux (Association of Social Service Centres of Quebec) in February 1975.

<sup>2</sup>Or in other words: for a variety of motivating reasons and situations an individual or a couple reaches the stage of wishing to control its fertility. They then seek the precise information they need to choose the method they will use in the future, either persevering or not in the use of the method or in the desire to control fertility.

THE FIRST NATIONAL CONFERENCE ON FAMILY PLANNING  
Convened by the Department of National Health and Welfare  
February 28 - March 2, 1972  
Ottawa Ontario

FINDINGS AND RECOMMENDATIONS ADOPTED AT FINAL PLENARY SESSION

General Principles

Delegates to the First National Conference on Family Planning, meeting in fifteen discussion groups,

Recognized and Emphasized That, freedom of choice being understood,

1. The right of all Canadians to family planning services involves an obligation on the part of individuals and families to determine, responsibly and realistically, the number and spacing of their children; and
2. Informed judgement and action by individuals and families requires not only availability of the full spectrum of birth control information and services, but knowledge and understanding concerning inter alia human growth and development, human sexuality and psycho-social relationships, the privileges and demands of parenthood, and the relationships among population growth and density, production and consumption of resources, and natural and man-made environments; and
3. Family life education and family planning involves responsibilities and opportunities not only for the individual and the

- family but also for religious institutions and other voluntary and community groups, the educational system, health and welfare agencies and professions, commercial enterprises, the media of communication, and governments at all levels; and
4. Family planning information and services as an essential part of a system of health and social services is a necessary but not a sufficient approach to public family and social policy, (by way of example, family and social policy also includes migration and settlement, housing, taxation, social security, environmental protection, etc.); and
  5. Coordination will therefore be essential at all levels in policy development, program planning, and organization and delivery of information and services.

#### Conference Recommendations

1. Family planning policy, programs and services should encompass the full range of birth control methods, sterilization (vasectomy and tubal ligation), abortion, fertility and genetics, as well as marriage and family (including adoption) counselling, and assessment, diagnostic, referral, and follow-up functions.
2. Family planning information and services should be available to any individual in Canada:
  - a) Without economic, geographic or other barriers to access.
  - b) Without reference to age or marital status.
  - c) Without legal liability (apart from negligence) to the provider of the service.

3. (a) Family planning services should become an integral component of all community-based health and/or social (personal) services.
- (b) Appropriate representation should be made to the governmental task force on community health centres, reporting to the federal and provincial cabinet ministers, to include family planning in the functions and services of such centres.
- (c) The further development of family planning clinics, mobile units, "store-front" services, youth service centres and similar programs, public and voluntary, should be encouraged and assisted to meet the needs of individuals and groups who are unable or unwilling to seek information and/or services in other ways.
- (d) A family planning clinic or equivalent service should be made a prerequisite for the accreditation of all general hospitals.
4. The federal government should develop, review continuously, and keep the public informed concerning, a national population policy; the policy should take careful account of such variables as fertility and mortality rates, immigration and emigration, and internal migration.
5. (a) Provincial and territorial governments should develop clear family life education and family planning policies,

program priorities, and, where relevant, standards, in the relevant areas of information and education, services, research, and teaching and training.

- (b) Through earmarking a percentage of their health and welfare budgets, or in some other identifiable fashion, provincial governments should provide expanded financial and staff support for family life education and family planning services public and voluntary.
6. High priority should be given in all Canadian provinces and territories to the provision of family life education programs, family planning information, and health and social services (including family planning) to relatively "isolated" communities and groups, including, for example, people in remote rural and northern areas, native peoples living in self-contained settlements, and adolescents living away from home.
  7. Provincial, territorial and municipal governments should develop as rapidly as possible a network of community health or personal service centres, designed to ensure maximum participation of people from the local community in policy development and program and service planning and evaluation.
  8. Provincial, territorial and municipal governments should employ social workers and others in their health units to complement the family planning services provided by health professionals.
  9. The proceedings and recommendations of the First National



Conference on Family Planning should be on the agenda in the immediate future of meetings of Ministers of Health, Social Welfare and Education, and various government departments, for discussion and coordinated planning and action.

10. (a) Federal funds should be earmarked to encourage and assist conferences or workshops on family planning in the territories, the provinces and the metropolitan centres.
  - (b) The planning and development of regional conferences or workshops should be a responsibility and an opportunity for interested individuals, groups and organizations in the particular area, especially for those from the areas attending this conference.
  - (c) The planners of these conferences should aim for an equal balance in their conference participants between laymen and professionals.
11. Through delegates to this conference, voluntary organizations and other appropriate channels, provincial and/or municipal governments should be pressed to take initiative and responsibility for the establishment of planning and development bodies (where they do not already exist), concerned with family planning and family life education, and involving representatives of health, welfare, and education, voluntary agencies, and consumer groups or others.
  12. Recognizing that language, ethnic, religious and similar

differences frequently impede the availability of family planning information and services:

- (a) Indigenous people should be trained and used to provide information, referral when requested, and follow-up activity concerning family planning for their particular groups or communities.
- (b) Indigenous people should also be involved in the planning and preparation of family planning information and educational material appropriate to their particular groups or communities.
- (c) Family planning publications, audio-visual and other resource materials should be made available in a variety of forms and languages, understandable to all sections of the population.
- (d) The federal Department of Manpower and Immigration should make available on arrival to new Canadians, in their mother tongue, information on Canadian health and social welfare programs, including family planning services.

13. Since a significant increase in information and education on family life and family planning is clearly required and acceptable, the federal government and provincial and territorial governments should earmark substantial funds for the production of resource materials appropriate to particular provinces, regions or groups, and for their dissemination through the media of communication.

14. Federal consultative services and financial assistance should be continued and expanded for experimental research and demonstration projects in both family life education and family planning services, especially for adolescents and young adults.
15. Federal financial assistance should be assured to foster required expansion of research in all aspects of family planning, for example, research on attitudes toward family planning on psychological aspects of sterilization and of abortion on the effectiveness of different methods of birth control and of organization and delivery of family planning services, on the socio-economic determinants and consequences of fertility, mortality and migration in Canada, on the consequences of population size and distribution of existing or projected socio-economic policies and programs.
16. (a) Through separate courses, through the systematic and coordinated introduction of material in established curricula, or through a combination of the two, education in human development, human sexuality and relationships, parenthood, family planning and demography (sometimes encompassed in the term "family life education") should be included in all school curricula from kindergarten through secondary school.  
(b) Parents, students, teachers and specialists from all relevant disciplines and professions should be involved in the planning, delivery and evaluation of family life

education programs and content in primary and secondary schools.

17. Governments at all levels should provide encouragement and financial assistance for the planning and development of family life education programs for adults by voluntary organizations, schools, colleges, universities and other appropriate bodies.
18. Federal and provincial encouragement and assistance, financial and otherwise, should be provided to ensure the planning and development of:
  - a) Training programs for specialists in the planning of family life education programs, and in the related education of teachers, social workers, health and other professionals in this area.
  - b) Curriculum, materials and courses in family planning and family life education, in education, social work, health and other university faculties or departments.
19. The federal government should establish a professional training program on birth control for all relevant professions and disciplines, including medicine, social work, nursing, sexology, psychology, etc.
20. The federal government should amend the Food and Drug Act and any other relevant legislation to eliminate restrictions preventing the advertisement of effective birth control devices and family planning pills on the same basis as other (advertised) prescribed drugs or products.

21. The federal government, with the cooperation of the provincial governments and other relevant bodies, should develop a directory of organizations and other resources active in family planning.
22. A representative of Metis Associations and others should be invited to attend all future conferences on family planning, national, provincial, territorial and local.

Recommendations of the Special Interest Group on Development of Family Planning Services\*

1. We recommend that provincial and territorial governments ensure that public hospitals provide family planning services including surgical procedures and counselling in accord with the principles of universality of services and freedom of choice by patients.
2. That this Conference most strongly urges on the governments of the provinces and territories the desirability of establishing inter-departmental family planning committees at an early date; these committees to consist of representatives of all departments involved with the family and to be charged with the responsibility for planning and implementing integrated family planning services appropriate to the province or territory.

Copies of this recommendation should be forwarded to the

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\*Not discussed in final plenary session of Conference.

voluntary family planning associations.

3. We further recommend that these provincial family planning committees be assisted by advisory committees representing interested voluntary citizen groups as well as local health, education and welfare agencies to advise on policies and services.
4. A plan for funding family planning services be developed by the federal government in cooperation with provincial governments to ensure that financial barriers do not prevent the development of provincially and locally coordinated comprehensive family planning services.

Recommendations of the Special Interest Group on Research in Family Planning\*

It is recommended that urgent priority be given to the following research areas:

1. A national fertility study, to examine the attitudes and behaviour of Canadians regarding fertility and family planning.
2. Operational research on the provision of family planning information and services is urgently required. Demonstration projects should be undertaken under a wide variety of conditions to examine different approaches to groups of different age, sex, socio-economic level, and ethnic character. These demonstration projects should be concerned with different uses

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\*Not discussed in final plenary session of Conference.

of manpower and methods, evaluate results and measure the relative cost-effectiveness of various approaches.

3. The relationship of family planning to social and health indicators.
4. Ongoing evaluation of family planning activities across Canada is urgently required.

STATEMENT BY THE MINISTER OF NATIONAL HEALTH AND WELFARE,  
THE HONOURABLE MARC LALONDE, TO THE HOUSE OF  
COMMONS ON THE SUBJECT OF ABORTION

September 11, 1973

In terms of general policy, the federal government does not regard abortion as an acceptable method of birth control; I should like that point to be made very clear. It does, however, recognize that unwanted conceptions may occur as a result of failure to use an effective method of contraceptive or any contraception at all. In these cases there may be justification for therapeutic abortion, not because the pregnancy was unplanned but because it may have given rise to conditions which, in the opinion of a therapeutic abortion committee, provide appropriate grounds for termination in accordance with the Criminal Code.

Birth control clinics are often visited by women seeking advice about unwanted pregnancies. To turn them away without help would be inhuman and could be regarded as tantamount to an attempt by the clinic's staff to impose their personal views about a subject on which society has expressed its collective will through the law.

It would seem that much of the difficulty in understanding the federal government's position arises from a



misunderstanding of the nature of abortion counselling. In the sense in which it is customarily employed and in which it is defined by this department, it involves the objective presentation of several alternatives within the laws of Canada as defined by parliament, and not the deliberate application of pressure to consider one option only.

## CASW POLICY STATEMENT - FAMILY PLANNING

### Preamble

Family Planning in Canada gained impetus in the decade of the 1960's when public attitude and acceptance encouraged activity in this interest area on a national level. In 1966 CASW developed a Policy Statement on Planned Parenthood which was distributed to the Common's Committee on Health and Welfare, the Prime Minister, the Presidents of Provincial Associations of Social Workers, as well as to the Federal Government departments and agencies likely to be involved in action recommended by this statement.

A number of significant developments have since occurred in both the public and private sectors. In 1968 the Federal Government amended an 1892 statute forbidding the dissemination of birth control information and the sale of contraceptives. Following the 1970 report of the Royal Commission on the Status of Women, the Government began promoting programs of public information, training of professionals, research and provision of funds in the field. In 1972 a Family Planning Division within the National Department of Health and Welfare was created.

The stance assumed by the Federal Government in the Family Planning Field essentially promotes the right of the individual to control his/her own fertility and to

exercise free choice in the practice of family planning.

### Objectives of Family Planning

The main objective of voluntary family planning is to assist all couples to plan the spacing and number of children so that they may (1) avoid unwanted births through prevention and treatment methods, and (2) plan for conception and treat infertility.

It is felt that social workers, by their training and expertise, can educate, interpret and provide effective follow-up procedures in family planning to their respective clients. In view of social work's concern for the family, we must assist individuals to control their own fertility with responsibility and self-directiveness. Social work involvement in family planning should be viewed as a potential area of preventative practice.

### Policy Guidelines

#### Role of CASW

The social work profession should assume a leadership role in promoting family planning policies and programs that are humane and accessible to all. CASW should encourage participation and dissemination of information and program development so that provincial associations, voluntary organizations, universities and social service agencies are able to utilize public resources for family planning programs. (The Canada Assistance Plan, for example, has a high potential for the development of provincial

family planning programs as expenditures on U.S. may be reimbursed by the Federal Government. UNFPA shall view family planning as a health service aimed at the preservation and enrichment of family life.

The Association should provide leadership in both the maximum utilization of government resources and in the establishment of a special program that will collect relevant data on population trends. The profession should disseminate information on infertility, fertility and changes of social and cultural attitudes of the population.

#### Focus of Family Planning Programs

Family planning programs should be an integral part of health, child and family care programs. The provision of information, counseling and means relating to family planning should be consistent with the individual client's choice. Clients should have access to social work, medical, psychological and religious assistance when they have problems with both infertility and fertility control.

#### Focus of Social Work in Family Planning Programs

Family planning programs should not be directed only to female clients, but also must endeavor to encourage active participation in this area by male partners as well. Decisions made jointly tend to promote greater contraceptive effectiveness. The aim of each individual approach of social workers in the area of

family planning, must be to value and promote responsibility in the sexual conduct of their clientele.

### The Client's Rights

Social workers must respect the client's rights to exercise self-determination in the use of family planning programs as well as in the selection of the method of spacing and limitation of child-bearing according to his/her personal beliefs and convictions. To this end, the client must be provided with access to the fullest possible knowledge of the choice of methods available. Respecting the right of free individual choice implies non-coercion on the part of others and entails an obligation of others to respect, project and promote the right to choose in full awareness of options and consequences of options. No one particular method or philosophy shall be imposed on the client who should be advised that the use or non-use of a particular method or service will not effect any other benefits to which he is entitled. This implies an obligation on informed persons to share their knowledge in instances where requested or required.

### Abortion

Consistent with the above, while CASW does not endorse abortion as a family planning method, we do accept the individual's right, when desirous of obtaining an abortion for social, medical or psychological reasons, to obtain professional assistance. CASW believes that social workers, by virtue of their training and experience can offer a specialized contribution to the diagnosis

and resolution of the problem as presented by a woman requesting an abortion. Social workers can give orientation to the woman and/or her family to whom a medical team refuses an abortion or who no longer wants an abortion. In addition, they can provide guidance and personal assistance designed to give an unwanted child an accepting environment. Social workers can also furnish post-intervention services which the woman and/or her family might need and should point out alternatives available to women seeking an abortion. However, in cases where the client's individual choice is that of abortion, even when they have been made aware of alternatives, we will ensure that the woman's free choice be respected and that she receives professional assistance, that she not be forced to resort to clandestine methods. We further recommend that research into the development of more efficient preventative methods be encouraged in all areas, and that the concept of family planning be given full support so that future incidents of unplanned pregnancies and consequent requests for abortions may be significantly reduced.

#### Social Workers' Rights

Individual social workers should have the right to engage or disengage from family planning practice in accordance with his/her personal belief or convictions but should ensure that adequate professional referral is made.

#### Role of Individual Social Service Agencies

a) When an individual social service agency and/or voluntary

family and child care agency cannot adopt a family planning service because of cultural, ethical, moral or religious reasons, such institutions should have a policy statement informing the community, social workers, and potential clients of this fact. Potential clients should be referred to other community resources if they desire service assistance in this area.

- b) Social service agencies and institutions should be encouraged to engage in the training of health, educational and other professional staff involved in family planning services. They should also be encouraged to engage in relevant research into the dynamics of population, human behaviour and the reproductive physiology.

#### Role of the Community

Active community involvement should be encouraged to achieve greater participation from the private sector so that comprehensive and responsive family planning programs on both local and national levels might be established and/or developed. (These should include other program components such as vocational, cultural and economic.)

#### Role of Federal Government

Relevant data and research should be correlated nationally by the Federal Government so that both the public and private sectors might accordingly introduce realistic and effective policies and programs. Social workers with recourse to adequate knowledge and

research data relevant to individual communities or provinces might then be able to solicit effective social legislation.

### Conclusion

Social workers should assume their professional responsibility in all relevant family planning programming. On the individual client level, social workers, through professional judgment, should assist and thus enable clients to receive the information they need for effective family planning. On the community level, social workers should promote citizen action through large scale community education. They should also encourage the creation of facilities for family planning services.

March, 1974



ANNUAL MEETING AND CONFERENCE 1975

THE CANADIAN COUNCIL ON SOCIAL DEVELOPMENT

Recommendations Passed by Plenary Session, June 17, 1975 Dealing with  
Family Planning and Abortion Services and Family Life Education Programs

Conception Control, Family Planning, Fertility Services and  
Family Life Education.

1. The federal, provincial and local governments should provide unequivocal support for family planning and conception control services, and ensure that all Canadians have ready access to the conception control and family planning measures of their choice.
2. Family life education programs should be offered on a universal basis in school systems, with the participation of parents in both the programs and the establishment of curricula.
3. Family life education courses should be available in adult education programs throughout Canada.
4.
  - a) Institutions responsible for the education of medical practitioners, nurses, social workers, teachers, clergymen and pharmacists should ensure that their curricula include components on human sexuality, conception control, family planning, abortion, and family life education, with special attention to the changing concepts of sex roles, the status of women, women's issues and problems.
  - b) Employers of medical practitioners, nurses, social workers, teachers, clergymen and pharmacists should provide opportunities and facilities for in-service training, in this matter.
  - c) Professionals referred to in paragraph a) in private practice should take responsibility for pursuing continuing education in these matters so that they will be prepared to provide such advice and counselling.
5. Medical practitioners and others involved in providing family planning information and services should provide accurate and up to date information which would allow the individual to make a free and informed choice.

6. The federal, provincial and municipal governments should make available adequate instructional, educational materials to professional people and voluntary groups concerned with conception control, family planning, therapeutic abortion services and for family life education programs.
7. All local public health units and social services agencies should be required to provide conception control and family planning services or take responsibility for referring a client to the appropriate service.
8. All types of voluntary social agencies, churches, and community groups should be encouraged to include educational courses relating to conception control and family planning in their programs.
9. Non prescription contraceptive devices should be made more readily available in drugstores and public places. Instructions for proper use should be included in packages.
10. The Canadian Council on Social Development (C.C.S.D.) should convene a committee of medical, family planning and other appropriate experts to investigate if any of the present effective methods of contraception which are only available through prescription, could be made available through non-medical sources and/or health personnel.
11. Publicity campaigns should be mounted by governments and family planning associations to promote family planning and responsible parenthood.
12. Sterilization should be readily available to all persons who freely choose this method and should be covered by provincial health insurance plans.
13. Conception control measures should be made available to every individual of childbearing age after proper counselling is received. This recommendation is addressed in particular to the provinces, who are urged to examine their legislation relating to the age of consent.

#### Abortion Services

14. Regardless of religious and moral opinions on the subject of abortion, Canadians should have a right to equal access to, and consideration for, therapeutic abortion services as legally provided under the Criminal Code, and the federal and provincial governments should ensure an adequate distribution of therapeutic abortion committees and approved

medical facilities for the performance of therapeutic abortions.

15. Medical practitioners, nurses and social workers should provide accurate information on abortion and should also provide non-directive counselling to any woman contemplating an abortion in order that she can reach an informed decision regarding whether to seek an abortion. If, for whatever reason an individual medical practitioner, nurse or social worker is unable to provide such assistance, he or she should refer the woman to an appropriate source of help.
16. Hospitals which perform abortions should be required to provide pre and post abortion counselling which should include information on conception control methods. Such counselling should be provided under the supervision of health care personnel or other duly qualified and appointed persons.
17. All mention of abortion as performed by qualified medical practitioners should be deleted from the Criminal Code. This should be interpreted as recommending that Section 251 of the criminal code be amended to apply only to abortions performed by persons not qualified as medical practitioners.

NATIONAL CATHOLIC COUNCIL OF SOCIAL SERVICES

EXECUTIVE BOARD

STATEMENT ON FAMILY PLANNING & RESPONSIBLE PARENTHOOD

Introduction

The past few years have shown a rapidly expanding interest in the family planning aspects of responsible parenthood within the Catholic community. Several significant documents have been issued by the hierarchy of the Church<sup>1</sup> but there has been little concrete follow-up or leadership offered within the Church, and in particular by professional social service organizations operating within the Christian framework.

Concern for this lack of leadership was clearly articulated at the 1972 Biennial Conference of the N.C.C.S.S. in the Workshop on Family Planning. Subsequently, a task force was struck (to be known later as the Atlantic Committee) to address itself to the total issue of family planning. This group presented a report to the January 1973 Board of Directors meeting. This report was then circulated as a working paper to member agencies and individuals across the country in order to provoke a dialogue on this very important issue.

Provoke dialogue it did! There was an extraordinary response from our members who submitted more than eighty reactions

to the working paper. This document is an attempt to bring together some of these ideas and opinions into a balanced statement on family planning and how it relates to Christian family life today.

### Terms of Reference

In formulating such a statement it is important to point out that our primary concern is the strengthening and enhancing of family life through the exercise of responsible parenthood. Responsible parenthood refers to the whole process of conceiving, nurturing, loving and educating a child to adulthood. As Christians we believe in the inherent value of human life and the essential nobility of procreation; we view child-bearing as a privilege to be embraced joyfully and responsibly within the married state.

It is because child-bearing and child-rearing are such an important responsibility that the decision to have a child should be made carefully and thoughtfully. Family planning is the process by which a couple can determine, if they wish, the timing, spacing and number of children to be born to them. In our view it is an essential aspect of responsible parenthood. The method chosen by any one couple should be a decision based on careful study and reflection on all relevant information, i.e., physical, psychological, social and spiritual.

This paper will attempt to confine itself to the

particular issue of family planning within the broader context of responsible Christian parenthood. It is not intended as a final statement but rather as another step in an on-going dialogue.

Abortion is not included within the terms of reference. In the opinion of the Board, abortion is not an acceptable method of family planning and constitutes an entirely separate issue.

### Some Perspectives

Christian tradition teaches us that the love between husband and wife reflects Christ's love for the Church; that God has chosen married couples to be the procreators of new life; that this role is to be embraced joyfully and enthusiastically by them.

The rapid changes that are taking place in our society sometimes makes such ideals seem remote from the way we see ourselves, our marriages and our families. Today, married couples are bombarded by pressures on all sides. Roles and expectations are constantly shifting; values which once seemed solid and permanent are now challenged or ignored. The result is a social climate in which families founder rather than flourish, in which children for many couples are viewed more as a burden than blessing.

It was concern for this situation, we believe, which

led the Canadian Bishops to issue their statement on *Humanae Vitae* in 1968<sup>2</sup>. In our view, it clearly restates Pope Paul's official sanction and encouragement of the principle of responsible parenthood. Within the context of its directives, it recognizes the possibility of a loyal dissent on the part of some who are unable to follow some of the points of Pope Paul's Encyclical on Human Life<sup>3</sup>. It also recognizes conflict situations wherein couples may judge it necessary to deviate from the given directives to which they adhere<sup>4</sup>. Continuing discussion, diversity of thought and interpretation within the Church community leaves couples confused and searching for guidance. Many express a desire and need for leadership to assist them in making informed, responsible decisions.

It is incumbent on the Christian community to give this leadership, to provide couples with all the help and information they need and want. This means, in our opinion, ready access to a full range of information regarding fertility control including the physical, psychological, social, spiritual and moral dimensions. Such a programme would draw on the combined wisdom of many disciplines. Ideally, it would be one part of a total programme of Family Life Education, including sex education, marriage preparation and enrichment, counselling, etc., offered within the context of Christian principles and values. Various programmes exist and models for "Family Life Education Centres" have been

proposed, but communities vary so greatly in their needs and existing resources that more research and experimentation should be conducted. The points that this paper is stressing are:

- 1) that family planning is an essential component of any comprehensive Family Life Education Programme.
- 2) that development of family planning services do not necessarily have to await the development of the total programme but can and should be initiated without delay.

There is a broader context to the issue of family planning than the concerns of the individual couple, for which the larger community and the social service professions must exercise responsibility. We are referring to the impact of specific population policies on large groups of people and whole nations. There is a tendency on the part of some of the more doctrinaire adherents of planned parenthood to ignore the wider ramifications of social policy in this area, and to promote family planning as a panacea, a solution to the social problems of poverty, inadequate housing, etc. In our estimation, this is a simplistic approach which fails to take into account all social and human variables. Continuing research is needed on a national and international level into the implications of population policies, as well as into the alternatives that may be open



to governments. The Christian community has an important contribution to make at this level and should make its voice heard.

### Conclusions

- a) Family planning is an essential aspect of responsible Christian parenthood and is to be supported in an atmosphere of human and moral dignity, and freedom of choice.
- b) Family planning is not a simple biological process but concerns the whole person, one's marriage and family. Hence, family planning programmes must draw on the combined wisdom of many disciplines including medicine, psychology, sociology and theology.
- c) Married couples have a need for, and a right to, all the information on which a responsible decision should be based. The Christian community has the responsibility of mobilizing a total range of information and resources to be placed at the disposal of families.
- d) Married couples must make the final decision as to the number of children they can care for and the spacing of these children. Responsible Christian parenthood implies this decision must be made with

due regard to Christian values and the teachings of the Church.

- e) Family planning services should be part of a broad programme of Family Life Education, but provision of the former should not necessarily await development of the latter.
- f) Family planning is not a substitute for just social policies, nor should it be promoted to the detriment of social programmes such as income security, housing development, etc., which are essential for the maintenance of healthy family life.

#### Recommendations

1. That information on all the physical, social psychological and spiritual aspects of family planning be made an integral part of family life education programmes, as well as public family planning clinics and counselling services, in order that married couples may make responsible and free decisions on parenthood.
2. That member agencies, institutions, organizations and individuals of the National Catholic Council of Social Services participate actively in the formation and growth of Family Life Education Centres which would offer, along with marriage preparation,

marriage enrichment, etc., a total range of information and services relative to child-bearing, child-spacing and child-rearing, in an atmosphere compatible with Christian principles and values.

3. That member agencies, institutions and organizations include in policy and planning adequate resources and staff training programmes to develop personnel knowledgeable and committed to the Christian principles and values inherent in responsible parenthood and family planning. Such personnel should be encouraged to be involved in family life education services provided directly or in conjunction with other community agencies or groups.
4. That the Canadian Catholic Conference be urged to encourage its member Bishops across Canada to actively support the creation of new, or the strengthening of existing Family Life Education Centres, family life and marriage preparation courses that will include as an essential component information on family planning as herein described. Further, that such support include sufficient resources and personnel, and that parochial and diocesan programming consider this an important part of pastoral planning.
5. That member agencies, institutions, organizations

and individuals be encouraged to actively collaborate with local, regional, provincial and national Church, interfaith, private and public bodies in the development and implementation of just social policies and programmes that will support and enrich healthy, wholesome marriage and family life.

6. That the N.C.C.S.S. urge its members to engage in, support and encourage research into models for family life education centres and programmes, on the need and effectiveness of component family planning services, as well as research into the social and moral aspects of fertility control on a national and global level.

#### REFERENCES

<sup>1</sup>Submission of the Canadian Catholic Conference to the House of Commons' Standing Committee on Health and Welfare, Oct. 11, 1966; Encyclical *Humanae Vitae*, Pope Paul VI, 1968; Statement of the Canadian Bishops on *Humanae Vitae*, 1968.

<sup>2</sup>Statement of Canadian Bishops on the Encyclical *Humanae Vitae* Plenary Assembly, Sept. 27, 1968.

<sup>3</sup>*Ibid*, para. 17.

<sup>4</sup>*Ibid*, para. 26.

October 26th, 1973.

GOVERNMENT OF QUEBEC  
DEPARTMENT OF SOCIAL AFFAIRS  
TRENDS IN FAMILY PLANNING

Family Planning Policy:

In the context of social policy, the primary objective is to create conditions favourable to the satisfaction of people's needs and to their self-realization. Among the conditions that are favourable, the possibility to determine how many children to have, when and under what circumstances, is essential.

A policy with the objective of providing the proper conditions to enable a couple (or individual) to have the number of children desired at the desired time and under the desired circumstances is what we mean when we speak of family planning policy. For this objective to be reached we must give attention to the conditions allowing freedom for all in this area as well as the capacity of each individual to exercise this freedom in a responsible manner.

Prevention

A preventive program of education in marital, parental and sexual relationships seems of primary importance in an improvement of the quality of life for a couple and consequently the quality of the surroundings in which their children learn about life. On this point the Royal Commission on the Status of

Women recommended family life education be taught to boys and girls from elementary school right up to the end of secondary school. The courses should deal not only with the biological side of reproduction but also with relationships between husband and wife and also between parents and children. Our Department, in co-operation with the Department of Education, wished to implement just such programs of family life education.

#### Services

This preventive action must also be carried out with adults, especially by making available to them services for education and counselling and (for persons facing more serious difficulties -- either marital, parental or sexual) services for consultation or medical or psycho-social treatment as needed.

#### Information

Placing the question of family planning at the level of the couple makes it appear essentially personal and voluntary. The freedom and convictions of every individual must be respected in this area. It must be noted, however, that to be capable of exercising that freedom in a responsible manner, it is essential that the individual possess a knowledge of the means available and the consequences of their use.

In this context, concurrently with the preventive action described above, comes the necessity of action at the level of dissemination of the proper knowledge to allow free and responsible

individual choice. By this we mean not only the means of controlling fertility in the sense of limiting births, but also and on the contrary the means of encouraging fertility (fertility clinics for example) as well as the means of postponing spacing or terminating it.

Implementation of information services within the local community service centres will make the information necessary for responsible parenthood available to all. Implementation of information and counselling services in hospitals or social service will, moreover, allow the needs of people with more serious problems to be met, such as the problems we have already mentioned. This does not exclude the possibility of creating specialized clinics in hospital centres or social service centres.

From September on, the Department will have information services on family planning in secondary schools, CEGEP's and universities, within the framework of its health services program, so that it can reach adolescents and young adults as quickly as possible.

### Training

These general guidelines imply a certain amount of training for the professionals involved in the provision of these services. In co-operation with the Department of Education and the various educational institutions concerned, the development of training programs for medical and para-medical staff as well as



for specialists in social services and related disciplines, is considered a priority.

It must, however, not be thought that everything remains to be done in the field of family planning. The province of Quebec in fact is one of the most advanced in this area. Departmental action in the past has consisted mainly of grants to organizations working in the area; over the past two years these grants have amounted to more than \$200,000.00.

Since January 1971 all services in the area of family planning have been recognized as insured services under Quebec Hospital Insurance.

We must point out also that the bursaries and research grants branch has approved more than \$110,000.00 in grants in the area of family planning within present research grants program.

Quebec, May 10, 1972.

## NOVA SCOTIA DEPARTMENT OF SOCIAL SERVICES

### Policy Statement on Family Planning

The Department of Social Services is committed to strengthening and improving the quality of family life. This commitment is being carried out through its own programs, such as public assistance, protection services for children and social development, and also through grants in aid and other forms of assistance to voluntary agencies, as well as citizen participation in welfare services. Responsible parenthood must always be a primary goal of welfare services and planned parenthood may frequently be one of the factors to be taken into account in achieving that goal. Planned parenthood means regulating the conception of children according to the personal, economic, physical, mental and emotional capabilities of parents through means best suited to their circumstances and wishes.

The Department of Social Services will assist families in fulfilling their responsibilities in the following ways:

1. Departmental staff, i.e., social workers and social service workers serving clients will provide basic information and guidance in respect to family planning to families and individuals where such is requested or is obviously a matter of concern to such families and individuals.

2. In all situations where clients are concerned about family size and general health problems, the social worker

or social service worker should immediately give consideration to referral of the person(s) to appropriate community resources for further professional and technical information and services.

3. Where the social worker or social service worker after assessing a case which is a basic part of his responsibilities or his caseload, is of the opinion that family planning would be helpful or necessary he should broach this subject as a part of his casework function with the family. He should not press the matter but he should make known what resources are available to the individual, if the client should wish to consult such resources.

4. The social worker or social service worker should bear in mind that the right of the client to self-determination is paramount and that under no circumstances should that right be jeopardized. In some instances the role of the social worker or social service worker will be to inform only. In any event the decision in respect to receiving information from the social service worker, social worker or from other community resources will be that of the client.

5. If a client requests family planning services and is eligible, the cost of this service may be included as an integral part of the cost of providing welfare services to the client.

6. The follow-up of referrals in respect to family planning services should be considered on the same basis as

the follow-up of any other referral.

7. In view of the responsibility of the Department of Social Services for wards the Department will assist wards and foster parents in the matter of birth control in the following manner:

When a ward or foster parent(s) requests information or guidance, or when a social worker or social service worker observes the need for information or guidance, this, following consultation with a supervisor, will be dealt with as part of the total casework function and a referral made to a family doctor or family planning centre if necessary.

January, 1974

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